

# Toward Equality of Well-Being: Strategies for Improving Minority Health



## STRATEGIC PLANNING AND COORDINATION PROCESS



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Office of the Assistant Secretary for Health  
Office of Minority Health



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# Foreword

America promises all its people the opportunity for life, liberty, and the pursuit of happiness, but in an imperfect world, opportunities, as well as obstacles, are not always equally distributed. We know that some of the obstacles that face our people—including the risk of illness, disability, or premature death—fall disproportionately on racial and ethnic minority populations within our society. We also know that many of these risks are preventable.

The Department of Health and Human Services has made a commitment to prevention and a commitment to help remedy the toll ill health exacts from minority people. That commitment was reinforced in 1985, when the Office of Minority Health was created in response to a departmental task force report that detailed the continuing disadvantages in health status faced by African-Americans, Asian-Americans, Hispanics/Latinos, Native Americans, and Pacific Islander-Americans.

It was further strengthened in 1990, when the Disadvantaged Minority Health Improvement Act, Public Law 101-527, was enacted. This law provided a formal statutory authority for the Office of Minority Health and authorized several other major departmental programs that serve large minority clienteles.

We continue to work to deliver on that commitment. Our goals are clearly stated. Healthy People 2000, the result of a major public-private collaboration, has identified many of the health outcomes our Nation must strive to reach. In response, the Department of Health and Human Services has devoted a larger share of its resources toward achieving those goals and toward achieving our goals for populations most at risk. Between 1988 and 1992, U.S. Public Health Service spending on health projects targeting disadvantaged minority people rose from \$175 million to more than \$600 million. These expenditures are above and beyond the resources the Department devotes to the health care system operated by the Indian Health Service and Native American tribal governments. These expenditures are also above and beyond the resources the Department devotes to Medicaid and Medicare.

For our part, the Office of Minority Health is committed to continue to advocate for a clearer focus on prevention, improved services, and more culturally and linguistically competent services to minority communities.

But more than Federal dollars and Federal commitments are needed. All segments of our society must become involved if we are to overcome the risks to life and health our people face. States, counties, municipalities, voluntary associations, community groups, individuals, and most importantly, families must all play a role in this national effort.

We are committed to helping foster and coordinate such efforts.

This document, *Toward Equality of Well-Being: Strategies for Improving Minority Health*, is intended to support such individual and collective action. It was developed by the U.S. Public Health Service's Office of Minority Health, in consultation with the Department's health agencies and with other public and private organizations that are devoting their energy and expertise to closing the minority health gap.



It provides more than 500 minority-specific strategies that could be used by public and private agencies to pursue the goals set forth in Healthy People 2000. Not all of these strategies will be appropriate for every jurisdiction, organization, or level of government. Not every problem area will be equally significant to every community. But everyone should be able to find portions of this book that will help in applying existing health knowledge and prevention techniques to the issues that are critical in his or her community.

Finally, this document describes the Office of Minority Health's long-range goal of establishing a system for tracking minority health program efforts and health status improvements. Ultimately, such a mechanism could greatly enhance our ability to measure our progress toward achieving a healthier America.

With this in mind, I encourage you to use this book. Select the strategies most appropriate to your organization and community and continue to pursue what you can do to help achieve a true equality of well-being for all our people.

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U.S. Department of Health and Human Services



# Introduction

"The Congress finds that racial and ethnic minorities are disproportionately represented among individuals from disadvantaged backgrounds [and] the health status of individuals from disadvantaged backgrounds, including racial and ethnic minorities, in the United States is significantly lower than the health status of the general population. . . ."

These words, which introduce the Disadvantaged Minority Health Improvement Act of 1990 (P.L. 101-527), bring to the national agenda the most compelling health issue of our time and thereby demonstrate a national commitment to redress health disparities among all Americans.

The health status of minority populations was first documented by the Department of Health and Human Services (DHHS) Secretary's Task Force on Black and Minority Health in 1985. Even with incomplete data, the Task Force's findings were grim: approximately 60,000 *excess deaths* occurred among Black people each year. This figure represented 60,000 men, women, and children who would not have died if age- and sex-specific Black death rates matched the nonminority death rate in this country.

As pointed out by the Secretary's Task Force, national data on minority populations and subpopulations other than Blacks are severely deficient and often nonexistent. Nevertheless, the growing body of data collected since 1985 indicates not only that the disparity in health status between the White population and Blacks as well as other minority populations is real, but also that the gap is widening. By virtually every health status indicator—life expectancy, mortality, morbidity, and utilization of and access to health resources—minorities fare more poorly than the general population.

The 20th century has witnessed striking increases in life expectancy for the U.S. population in general, although these increases have not accrued equally to all. For example, a Black male born in 1988 could expect to live 64.9 years, compared with 72.3 years for a White male. Between 1980 and 1988, the difference in life expectancy between Black and White males increased from 6.9 to 7.4 years. The continuing differential is due in part to recent increases in death rates for Black males under age 45 because of AIDS and homicide. (1)

As reported in 1988, Blacks had the highest death rates among all age groups, and Native Americans had the second highest death rates up to age 65. The greatest Black-White differences occurred in the 25- to 44-year-old age group and lessened with increasing age. This means that after age 65, the Black-White disparity was minimal, and Native Americans actually had lower death rates than Whites. Asian persons at every age and for most causes of death had the lowest death rates of any group in the United States. (1)

Although the three leading causes of death (i.e., heart disease, cancer, and cerebrovascular disease) are the same for all populations, variations in causes of death and death rates occur among certain racial and sex groups and among different age groups. In 1988, injuries were the second leading cause of death for Native

American males and the third leading cause of death for Black males, Asian and Pacific Islander males, and Native American females.

Among children 1 to 14 years old, unintentional injuries were the leading cause of death in 1988, but the injury death rate for Native American children was 85 percent higher and for Black children 55 percent higher than for White children. Homicide was the second leading cause of death for Black children under age 15 and the leading cause of death for Blacks aged 15 to 44.(1)

HIV infection, a relatively new disease, is increasingly and disproportionately affecting minorities. In 1988, among adults 25 to 44 years old, HIV infection was the second leading cause of death for Hispanics, accounting for 15 percent of all Hispanic deaths, and the fourth leading cause of death for Blacks, accounting for 12 percent of all Black deaths. Among Whites, deaths from HIV infection were responsible for 8 percent of all deaths in this age group. (1) Today, AIDS is the leading cause of death among Black women 15 to 44 years old in New Jersey and New York. (2)

As of the end of September 1991, the Centers for Disease Control reported that nearly 29 percent of all AIDS cases in the United States have occurred among Blacks, who represent 12 percent of the American population, and 16 percent have occurred among Hispanics, who represent less than 8 percent of the American population. (3) Blacks and Hispanics account for more than three-fourths of all cases of AIDS in children under 13 and are also disproportionately represented among older children with AIDS. (3)

Certain types of cancers are among the other diseases that disproportionately affect minorities. Blacks have higher mortality rates than Whites for many cancer sites and experience poorer survival. For all sites combined, Blacks have significantly higher age-adjusted cancer incidence rates, and the disparity in incidence is increasing. The cancers for which Blacks have higher incidence than Whites include oral cavity, esophageal, lung (males), female breast (under age 40), cervix uteri, prostate, stomach, and pancreas. (4) Southeast Asian immigrants have an incidence of liver cancer that is 12 times higher than that of the White population, a fact that is associated with the high rate of hepatitis B among these populations. (5)

Other diseases, conditions, and risk factors of particular concern for specific minority populations include (1,5):

- Diabetes among Blacks, Mexican Americans, Puerto Ricans, Cubans, Native Americans, and Alaska Natives. (Among some Native American tribes, the prevalence of diabetes is as high as 20 percent. [5])
- Cirrhosis among Native Americans and Hispanics.
- Tuberculosis among Southeast Asian immigrants.
- Adolescent pregnancy among Blacks.
- Infant mortality among Blacks and migrant workers, of whom Hispanics constitute the largest group.
- Obesity among Blacks, Native Americans, and Hispanics, especially Mexican American women.
- Smoking among Hispanic men and teenagers, especially Mexican Americans, Cubans, and Puerto Ricans, and among Southeast Asian men.
- Drug use among Blacks, Puerto Ricans, Cubans, and Mexican Americans.

In spite of their poorer health status, minorities have less access to health care and less health care coverage. Data available on the Black population illustrate

this point. Blacks have fewer physician contacts and are more likely to seek primary care from hospital outpatient departments than Whites. Blacks also make fewer visits to dentists. In 1989, in terms of health care coverage for persons under age 65, the Black-White disparity was repeated (1):

- Private insurance  
Blacks—59.2 percent  
Whites—79.7 percent
- Medicaid  
Blacks—17.1 percent  
Whites—4.5 percent
- Not covered  
Blacks—22 percent  
Whites—14.5 percent

Another important disparity that is closely related to health status is socioeconomic status: a much larger portion of Black, Hispanic, Asian and Pacific Islander, and Native American and Alaskan Native peoples live in poverty than Whites. In 1980, 28.2 percent of Native Americans and Alaskan Natives lived in poverty, compared with 12.4 percent of Whites. In 1987, 33.1 percent of Blacks and 28.2 percent of Hispanics lived below the poverty level, compared with 10.5 percent of Whites. Among children, the disparities are even more appalling. Whereas 16.2 percent of White children under age 16 lived in poverty in 1987, 46.6 percent of Black children and 40.6 percent of Hispanic children lived below the poverty level. (6)

Although the statistics paint a bleak picture, the true magnitude of the problem is not yet fully known, both because of lack of data and our incomplete understanding of the complex social, cultural, economic, environmental, genetic, and other factors that contribute to this travesty. Nevertheless, the numbers and the available information clearly indicate the need for immediate attention to these pressing national problems.

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# Setting Goals and Developing Strategies

The initial response to the challenge of improving minority health came from the Secretary's Task Force on Black and Minority Health, which also brought the problem to the Nation's attention. That Task Force, composed of representatives from the Federal Government (who received input from the public and private sectors), developed more than 400 recommendations for activities designed to improve the health status of minority populations across the country. The recommendations focused on the six causes of death—cancer, cardiovascular disease and stroke, diabetes, intentional violence, infant mortality, and substance abuse—that accounted for more than 80 percent of the excess deaths among minorities and three crosscutting health issues that influence overall health status—access and health care financing, data development, and health professions development. The Task Force's recommendations served two purposes: they served to raise awareness of minority health problems and provided an overall framework for action. Nevertheless, the recommendations were only the starting point on the long road to be traveled toward the destination of improved health for our Nation's racial and ethnic minorities.

Every journey requires planning and coordination, and these crucial functions reside with the Office of Minority Health (OMH), which was established in 1985 within the Office of the Assistant Secretary for Health (OASH), Public Health Service (PHS), in response to the Secretary's Task Force's findings. More recently, the Disadvantaged Minority Health Improvement Act of 1990 requires OMH to establish long- and short-range goals and objectives and to coordinate all other activities within the Department that relate to disease prevention, health promotion, service delivery, and research concerning such individuals. OMH serves a coordinative function at the Federal level by defining objectives for DHHS activities that target minority populations, organizing and planning activities, serving as an information resource, and providing technical assistance to States and the public and private sectors. Through its active involvement with the broad health community, OMH also is a catalyst for initiatives being undertaken in communities, by organizations, and at every level of government. OMH is integrating all these activities to develop a system for planning, coordinating, and tracking minority health efforts throughout the Government, as well as the public and private sectors. As presented here, this system includes specific strategies for action that apply existing health knowledge and prevention methods in ways that are acceptable to minority communities.

## National Goals and Objectives

The national disease prevention and health promotion initiative, first delineated with the publication of *Healthy People* in 1979, had important implications for minorities because of the promise it offered for preventing premature death, disease, and disability and for improving the quality of life. The latest iteration of that initiative, *Healthy People 2000*, establishes three broad goals for the year 2000:

- Increase the span of healthy life for Americans.
- Reduce health disparities among Americans.
- Achieve access to preventive services for all Americans.

*Healthy People 2000* also presents opportunities for reaching these goals in the form of measurable targets or objectives, including 157 objectives that specially target Asian Americans and Pacific Islanders, Blacks, Hispanics, Native Americans and Alaskan Natives, and persons with low incomes. A listing of the *Healthy People 2000* objectives for special populations is provided in appendix A.

*Healthy People 2000* challenges states and communities to translate national objectives into State and local actions. Some states are responding to the challenge by assessing specific needs of their minority communities and setting priorities that will enable them to meet those needs.

Toward that end, 11 States now have offices of minority health, and approximately another 9 are in various stages of developing a minority health focus within their health departments. In California, four racial and ethnic task forces have developed draft documents on how the *Healthy People 2000* objectives should be adapted to address the health needs of California's diverse ethnic and racial minority populations. Texas has developed a Texas Year 2000 Minority Health Implementation Plan, based on the Texas Year 2000 Health Objectives. The New Jersey Office of Minority Health has sponsored a series of forums to solicit public comments on the State Health Commissioner's Interim Report on Minority Health.

Ohio's experience underscores how essential community input is to health planning and programming. The Ohio State Commission on Minority Health spent much time and effort holding hearings and soliciting testimony from minority communities about their concerns and frustrations with the health system. Contrary to the expectations of the Commission before these hearings, people reported most concern about mental health and most frustration with the mental health services. This example emphasizes the point that each community is different and will require its own approach to adequately address its own priorities. To achieve the national health objectives, communities must have an opportunity to identify their greatest health needs and to establish their highest priorities.

Oregon has engaged in another kind of priority setting to provide basic health care to people living in poverty. Recognizing that Government, through the Medicaid program, does not have enough money to pay for all medical services, Oregon determined how much money it could spend on health care and what medical services should be covered. The Oregon Basic Health Services plan lists 709 health services in priority order of those most likely to be beneficial. Based on the amount of money available, all Medicaid recipients and others living in poverty and uninsured will receive medical services for diseases and conditions up to a certain ranking on the list (through number 587, esophagitis, for 1991).

In addition to activities sponsored by the Government, national disease-focused organizations are discovering that their educational efforts must be culturally appropriate to reach persons at highest risk. Communities faced with overwhelming problems related to poverty are directing special attention to the minority populations that constitute a large proportion of persons living in poverty. At all levels—Federal, State, and local—the most effective approaches for addressing the health needs of minority populations are being discussed.

### **Strategies for Reaching the Objectives**

Clearly, many opportunities exist for devising innovative strategies to meet the national goals and objectives outlined in *Healthy People 2000* and for improving minority health. Just as the minority-specific goals are essential, so are strategies that minority communities can use. Those who are most knowledgeable about minority



health issues and those who are already organized have a responsibility to share their knowledge and to build partnerships throughout the country. Not only will such sharing improve the level of knowledge, but it also will stimulate more creative strategies for reaching these target populations.

The Office of Minority Health, in its lead role to coordinate and advocate minority health issues, continues to serve as an information broker and to solicit the ongoing involvement and support of the broad community—Federal, State, and local. OMH has been engaged in an extensive planning process, described in appendix B, that resulted in the development of more than 500 minority-specific strategies that together constitute a roadmap toward the destination of improved health status for minorities. The contributors to the process included PHS agency representatives working in Health Issues Working Groups, who drafted goals and objectives for improving minority health in priority areas, and non-Federal experts serving in Technical Review Groups, who provided the technical and community expertise needed to develop strategies for meeting the goals and objectives. Appendix C lists the members of these two groups convened by OMH. **This report presents a roadmap of recommended strategies developed through this strategic planning process to involve all the players—government agencies, policymakers, private organizations, public institutions, communities, and others involved in minority health issues.**

Because the predominant health issues differ among minority populations and subpopulations and among communities, it is unlikely that one or even several minority-specific strategies can be devised that will enable us to meet the national objectives. Rather, States, counties, and communities must assess their own situations, set their own priorities, and adapt strategies such as those presented here or develop new strategies to address their specific issues.





# The Strategies and How to Use Them

The strategic roadmap to improved minority health is, like any roadmap, a paper guide: it displays a wide range of information and offers a vast array of choices for reaching the destination. In presenting this strategic roadmap to the Nation, the Office of Minority Health recognizes that this is not the *only* map and that there is no single route or best route. All travelers are free to choose the routes they want to follow. Further, there is no expectation that every route chosen will lead straight to the destination or that even what appears to be a super highway will not have an occasional sharp curve. What is expected is that choices will be based on local needs, concerns, and resources so that the strategies are viable and feasible for the communities in which they will be implemented. What is hoped is that many organizations and individuals will commit to embarking on the journey toward the *Healthy People 2000* goals. Our common destination—elimination of the minority health disparity—will be reached only through cooperation and partnerships among all sectors of society.

**This volume lays down strategic tracks in the six priority health areas—cancer, cardiovascular disease and stroke, diabetes, intentional violence, infant mortality, and substance abuse—that constitute 80 percent of the excess mortality experienced by minorities. HIV/AIDS is included as well because of the increasingly devastating impact the disease is having on minority and low-income populations.** Other strategic tracks are delineated for crosscutting issues that influence overall health status, namely, access to health care and financing, data development, and health professions development. In this respect, this publication follows the lead of the *Report of the Secretary's Task Force on Black and Minority Health*.

Within each track are minority-specific strategies related to outreach, patient education, delivery and financing, non-Federal health professions education, Federal health professions education, building the capacity of non-Federal health resources, data, and research.

The strategies also tie in to and complement the national goals and objectives of *Healthy People 2000*. For example, one patient education strategy in the diabetes track is to:

- Educate all minority individuals with diabetes and their providers about lower extremity problems and the necessity of self-care for these problems.

This strategy ties in to recommendation 2 of the Secretary's Task Force:

- The Department should ensure that its materials, programs, and technical assistance for patient education are responsive to minority population needs, especially those provided in specific health care service settings such as medical, community-based, school, and worksite locations. Emphasis should be given to those public health topics that have the greatest impact on death and disability in minority populations. Concomitantly, attention should be given by the Nation's schools and

universities to training health care providers and educators to be sensitive to minority cultural and language needs.

and to Section 1707(b)(6) of the Disadvantaged Minority Health Improvement Act of 1990, which stipulates that with respect to the health of disadvantaged persons, including racial and ethnic minorities, the Office of Minority Health should:

- Develop health information and health promotion materials and teaching programs, including:
  - models for the training of health professionals;
  - model curriculums to be used in primary and secondary schools and institutions of higher learning;
  - materials and programs for the continuing education of health professionals;
  - materials for public service use by the print and broadcast media; and
  - materials and programs to assist health care professionals in providing health education to their patients;

and to the *Healthy People 2000* objective (17.10c) to:

- Reduce lower extremity amputations due to diabetes among Blacks with diabetes to no more than 6.1 per 1,000 Blacks with diabetes (baseline 10.2 per 1,000 in 1984-87).

This strategy can be operationalized after, for example, a community with a significant number of minority people with diabetes decides that this patient education strategy is important and develops specific action steps for implementing it. These action steps might include contacting the OMH Resource Center and other appropriate national and local resources, such as health professionals, the local health department, or the American Diabetes Association, to determine whether appropriate patient education materials are available. In addition, the community could use the *Healthy People 2000* objective and baseline data or set its own objective with reference to community-specific baseline data.

In this way, the strategies provided here will become more than a roadmap or a paper guide. They will become the community-driven initiatives that will determine whether the national goals and objectives are met and whether the destination of improved minority health is reached. The next step, therefore, is that agencies, organizations, States, communities, and individuals make the commitment to set out toward that destination.

# Tracking Progress and Correcting Our Course

The importance of current, consistent, reliable, and well-focused data in any strategic effort cannot be overstated. Sound data are the foundation for a true understanding of minority health care issues. Ultimately, the process of addressing these issues should be guided by the information gathered in the data collection process. These same data then become the baseline against which future progress can be measured.

According to the 1988 *Report of the Subcommittee on Minority Health Statistics of the National Committee on Vital and Health Statistics*, a national undertaking to generate such data would improve existing sources of health data in three ways:

- It would enhance cooperative efforts with the States regarding the recording of vital statistics.
- It would incorporate specific racial and ethnic identifiers in databases.
- It would oversample selected minorities in national surveys.

Almost all major national data systems now collect data on race and ethnicity, but historical data are lacking as well as data on certain minority subpopulations. Morbidity, mortality, access to and use of health services, and health behavior vary markedly by age, race, gender, and socioeconomic status. These data are essential to the development of effective health improvement strategies. A data collection policy that acknowledges the importance of collecting minority data dramatically enhances our capacity as a Nation to form sound public policy directed at minority health education, disease prevention, and treatment. Without such a policy, the quality of the strategies designed to ameliorate these problems will be seriously compromised.

The Public Health Service has an ongoing Health Data Policy Committee, which recently established the Task Force on Minority Health Data to assist in improving minority health data activities within PHS. The Task Force is reviewing PHS data plans and activities in light of current and anticipated policy and programmatic goals, data needs, identified gaps, uses of data, and other issues. The Task Force is considering the *Healthy People 2000* objective (22.4) that calls for the development and implementation of a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities and persons with low incomes, and establish a mechanism to meet those needs. Data needs related to other policy goals such as those specified in the Disadvantaged Minority Health Improvement Act are being considered.

## Minority Health Tracking System

The Office of Minority Health, with its broad responsibility for coordinating minority health activities, is currently developing the Minority Health Tracking System, a computerized database that will allow the Office to identify, store, update, and retrieve pertinent information. The database will include comprehensive data on



the health status of all minorities, including minority subgroups, as well as existing public and private initiatives and funding for minority health activities.

This Minority Health Tracking System consists of two components:

- Programmatic Database.
- Statistical Database.

The Programmatic Database initially will provide information on PHS-supported grants and contracts related to minority health. Later it will be expanded to include data on such grants and contracts across DHHS, on program activities of other Federal agencies, and, ultimately, on other public and private sector efforts. The companion component, the Statistical Database, will provide a compilation of statistics on the 10 health issues of particular concern to minority populations, collected from various sources, including the National Center for Health Statistics. Information included in this tracking system will be especially helpful for setting objectives and measuring progress, as well as for information dissemination and trend analyses.

Among the many potential uses of this two-component tracking system are the following:

- As a tool to aid in the identification of specific research and service delivery gaps and opportunities, which will provide a basis for developing short- and long-range plans to support research on minority health and provision of services to minority populations.
- As a mechanism to aid agency program staff in monitoring trends and emphases in federally supported minority health research and service activities.
- As a mechanism to facilitate program coordination efforts among public and private sector agencies currently supporting or planning to support minority health programs and projects.
- As a reference for investigators and service providers in the minority health community.
- As a tool to aid agency program staff in preparing responses to inquiries from the public and private sectors.

When fully operational, the Minority Health Tracking System will be unique. It will allow OMH to monitor the kinds of programs being conducted by the Federal Government and the public and private sectors and to determine how the health status of minorities is changing over time. With this system, the Office will be better able to respond to requests from various sectors of the broad health community and to anticipate some of the programmatic and service needs of minority communities across the country. **Finally, and perhaps most important, the system also will allow OMH to track and monitor progress being made toward achievement of the goals and objectives set forth in *Healthy People 2000*.**

This is envisioned as an ongoing process with much of the necessary expertise flowing upward from the broad community. In other words, it will represent “bottom up” or “outside in” planning and implementation. Therefore, OMH will continue to invite community representatives to assist in its periodic review and refinement of the strategies, goals, and objectives for improving minority health.

## **The Vision for the Future**

As we move into the last decade of the 20th century, the situation with respect to minority health is that we have accomplished the following:

- Identified the problem.
- Increased awareness of the issues.
- Developed some institutional framework.
- Outlined national goals.
- Delineated objectives.
- Proposed strategies for attaining those goals and objectives.
- Developed a system for tracking progress.

All of this has been accomplished through the efforts of the many individuals, organizations, and agencies committed to redressing health disparities.

Nevertheless, all of these activities have brought us only a few steps along the long road that lies ahead. Whether we progress with due speed down the road to improved minority health will depend on how successful we are in implementing minority-specific strategies in programs across the country. As communities achieve their specific goals, we as a Nation will move closer to our goal of improved minority health.

The Office of Minority Health will continue to serve as the Federal Government's focal point for planning and coordinating minority health activities and to promote the cooperation and collaboration of individuals within Government and the broad health community who are involved in these activities. OMH will endeavor to improve our information base and to build networks of people who are working on health and social issues affecting minority people. These minority health networks will be able to take on the jobs that no one office, agency, or program can do alone and that are intended to provide effective means of shaping administrative actions and community decisions.





# **The Roadmap: Strategies for Improving Minority Health**

## ***Diseases***

- Cancer
- Cardiovascular disease and stroke
- Diabetes
- HIV/AIDS
- Intentional violence
- Infant mortality
- Substance abuse

## ***Crosscutting Issues***

- Access and financing
- Data
- Health professions



# Cancer

## CANCER: Strategic Goals and Objectives

### Goal I: Outreach

Develop outreach communications about cancer risk reduction, prevention, detection, early diagnosis, and treatment targeted specifically to minority and minority subgroup populations of differing ages and levels of risk. (Secretary's Task Force Recommendation 1)

#### *Objectives*

Convene a working group of cancer experts, Federal officials, media experts, social marketing strategists, individuals knowledgeable about minority communities, departments of health, community leaders, and health educators to:

1. Design a media-based, long-term campaign targeted to specific behaviors in specific groups. Address both minority education and attitude change on the part of majority populations. (long term)
2. Determine the method of communication that is most appropriate for the targeted population. (short term)
3. Develop messages that will reach undereducated, disabled, and/or non-English-speaking populations. (short term)
4. Implement and evaluate specific media approaches using social marketing strategies to create a demand for early screening, detection, prevention, and cancer risk reduction for minorities. (short term)
5. Address the influence of commercial advertising and other lobbyists and civic organizations that target minority populations, including tobacco, tobacco products, and alcoholic beverage companies. (short term)
6. Encourage agencies, including cancer centers, to expand their efforts in early detection or health promotion and prevention, education, and referral networks for minorities, particularly children and young people. (medium term)
7. Foster increased ties with private and community agencies dealing directly with minority populations. (medium term)
8. Promote joint efforts among voluntary organizations, the Federal Government, industry, and public, private, and other organizations to bring general cancer education to minorities. (medium term)
9. Work with regional coordinators to identify and make fullest use of available minority community-based resources. (medium term)
10. Develop joint education programs for minorities in 25 high-risk communities across the country. (medium term)
11. Identify and use the most appropriate voluntary organizations and Federal agencies to bring general cancer education to older persons from minority groups. (medium term)

12. Provide training in cancer control for regional coordinators. (short term)
13. Provide financial incentives to encourage activities involving indigenous community health education volunteers. (immediate)
14. Encourage the use of available resources such as the National Black Leadership Initiative on Cancer, the Cancer Information Service, and others. (short term)

## **CANCER**

### **Goal II: Patient Education**

Educate minorities and public and community leaders about cancer risks, including risks peculiar to their own minority group, in the areas of early detection and warning symptoms, cancer subgroups at high risk, risk reduction, and early detection. (Secretary's Task Force Recommendation 2)

#### **Objectives**

1. Designate as high priority programs that inform and educate minority populations about the important role of early detection as a health benefit. (short term)
2. Develop cancer prevention and education programs specifically targeted to older minority individuals. (medium term)
3. Educate minorities about the dangers of health fraud and medical quackery in cancer. (short term)
4. Educate consumers about their rights to receive adequate care from providers supported by third-party payors, and encourage consumers to demand appropriate health care assertively, including the psychosocial aspects of therapy. (short term)

## **CANCER**

### **Goal III: Delivery and Financing**

Incorporate as a component of all health care benefits plans reimbursement for preventive health and other services, including early detection, screening, and other preventive measures. (Secretary's Task Force Recommendation 3)

#### **Objectives**

1. Work with business leaders, unions, and employee benefits experts to implement worksite cancer screening programs. (short term)
2. Develop legislation that addresses lower and upper limits of payment for drugs and catastrophic illness insurance coverage. (long term)
3. Ensure that all health promotion messages to a specific organization or occupation contain information on screening for cancer and early detection. (medium term)
4. Evaluate the extent to which current financing strategies reimburse for cancer preventive services. (medium term)
5. Encourage third-party coverage of health services such as technical development of screening standards and dissemination of screening guidelines for minorities. (medium term)

## **CANCER**

### **Goal IV: Non-Federal Health Professions Education**

Recruit more minority candidates to work in the public health sector with the dual intent of increasing minority staffing in health care and cancer research and increasing the number of biomedical researchers who study minority-related cancer. Develop collaborative private and governmental programs of professional education and training for minority health care providers to ensure that optimal cancer health care personnel are available and accessible to minority communities. (Secretary's Task Force Recommendation 4)

#### ***Objectives***

1. Educate minority health professionals about cancer risks through ongoing workshops. Organizations such as the National Medical Association and other minority health professions associations are candidates to lead such efforts. (short term)
2. Emphasize in all health professions training the benefits of avoiding cancer risk factors, the importance of cancer screening, and the need for a continuum of care for patients who develop cancer. (short term)
3. Introduce current concepts of cancer detection and prevention in medical curricula and training programs. (long term)
4. Include as part of geriatric training the importance of cancer screening. (long term)
5. Incorporate specific risk factors associated with race and ethnicity into the curriculum of health professionals through the utilization of offsite community-based training opportunities. Include such elements as rehabilitation services, coordination, discharge planning, followup, and family counseling. (long term)
6. Incorporate the principles of case management or care coordination into the curriculum of health professions training, and give direct instruction on detecting cancer. (long term)
7. Promote group-specific educational programs for health professionals to encourage the use of cancer screening information. Include training for primary care physicians on cancer detection. (medium term)
8. Educate primary care physicians about cancer detection, state-of-the-art treatment, and referral. (medium term)
9. Evaluate the effectiveness of current methodologies for providing continuing professional education to health care providers serving minorities. (medium term)
10. Improve the care and management of minority patients in primary care settings by involving academic institutions in the process of continuing professional education. (immediate)
11. Establish and expand computer linkages to provide tutorial information to health professionals in rural and isolated delivery systems. (medium term)
12. Design, develop, and implement a general training program for medical care providers that stresses the utility of clinical screening services in



general clinical practice and that is targeted specifically to those who serve minority and underserved populations. (medium term)

13. Use the training authorities of agencies having a proprietary interest in cancer to identify and recruit minority candidates for all levels of health professions education. (medium term)
14. Eliminate barriers to minority access health services professions and research careers. Develop a personnel plan for the identification, recruitment, and training of minority individuals to work in the public health sector. Provide incentives to biomedical researchers who study minority-related cancer, and recruit minority candidates for pre- and postdoctoral fellowships. (medium term)
15. Develop cancer training and education incentive plans to encourage minority persons to choose careers in oncology and oncologic research. (medium term)

## **CANCER**

### **Goal V: Federal Health Professions Education**

Develop cooperative Federal professional education programs and incentives for minority participation in cancer-related training. (Secretary's Task Force Recommendation 5)

#### ***Objectives***

1. Expand the scope of the current National Cancer Institute (NCI) agreement with rural and isolated community and migrant health centers to provide health professionals with online access to relevant and timely information such as Physicians Data Query. (medium term)
2. Increase Federal dissemination of cancer information to physicians treating substantial numbers of older persons from minority groups and to the patients themselves. (long term)
3. Encourage and expand existing Federal programs for the training of minority persons in basic and clinical oncologic research. (medium term)

## **CANCER**

### **Goal VI: Building Non-Federal (State, local, and private) Minority Resources for Cancer Research, Prevention, and Treatment**

Identify the special cancer research, prevention, and treatment needs of minority populations and subgroups of these populations and promote active non-Federal participation in meeting those needs. (Secretary's Task Force Recommendation 6)

#### ***Objectives***

1. Encourage early detection agencies that can provide resources in support of health promotion and screening for cancer. Youthful minority populations should be stressed. Foster increased ties with private and community agencies dealing directly with minority populations of interest for the purpose of distributing cancer information. (medium term)
2. Use regional coordinators to identify and make fullest use of available community-based resources in disseminating information on cancer

resources. Include the National Cancer Information Service, American Cancer Society, National Black Leadership Initiative on Cancer, cancer centers, and others. (medium term)

3. Cooperate with voluntary groups such as the Gerontologic Society of America to identify particular prevention and treatment needs of older minority populations. (short term)
4. Encourage the involvement of geriatric health care systems in overall cancer control efforts. The Veterans Administration is one source of expertise. (medium term)
5. Implement cancer education, screening, and control efforts in private practice, governmental, and proprietary health care institutions with large minority populations. Include services such as psychosocial support and transportation in addition to standard treatment. (long term)
6. Increase collaboration among Federal sector and minority educational institutions to improve cancer health care education and training. (medium term)
7. Collaborate with business leaders and employee benefits experts to implement targeted workplace programs of risk reduction and early diagnosis for minorities. Community organizations might include local American Cancer Society, Gray Panthers, and consumer affairs offices at State and local levels. (medium term)
8. Encourage the development of price monitoring strategies for cancer chemotherapeutic agents purchased through pharmacies in minority communities. (medium term)
9. Promote increases in minority patient accrual in commercial pharmaceutical clinical trials of cancer therapies. (long term)
10. Promote widespread application of breast and cervical cancer screening techniques for early detection. (long term)
11. Develop improved multidisciplinary case-management techniques such as rehabilitation, social support, and appropriate patterns of followup after diagnosis. (long term)
12. Encourage and expand the minority components of programs such as the National Smoking Education Program of the National Heart, Lung, and Blood Institute or the Smoking, Tobacco, and Cancer Program of NCI. (long term)
13. Ensure nondiscrimination and equal employment opportunities for persons recovering from cancer. (immediate)
14. Urge consumer affairs departments in local, State, and other governmental organizations to collect and publish information concerning the costs and availability of medications in minority communities. (immediate)

## **CANCER**

### **Goal VII: Data**

Develop and maintain minority cancer data systems to capture baseline data on cancers and to assess needs, services, and quality of health services and to monitor the effectiveness of educational efforts and prevention programs. (Secretary's Task Force Recommendation 7)



### **Objectives**

1. Reinforce NCI activities to develop a health information and promotion service and to improve clinical study of minority individuals. (medium term)
2. Establish an expanded cancer control surveillance system to monitor communities with a large proportion of minority and underserved persons. (medium term)
3. Identify statistical and methodological problems in collecting, analyzing, and presenting health data on small samples and special ethnic groups. (short term)
4. Identify data needs, gaps, and inconsistencies to enhance database construction. (medium term)
5. Develop a computerized system to integrate a comprehensive database on the health profile of minorities. Improve cancer epidemiology of minority populations. (medium term)
6. Implement a computerized system for monitoring programmatic activities and provide for individual assessment of activities targeting the various minorities and subpopulations. (medium term)
7. Seek private and public funding for the design, development, and implementation of selected surveys in minority and underserved communities to determine the level of screening and detection, cancer prevention, quality of preventive care, and the quality of cancer therapy activities. (medium term)
8. Improve the use of available data systems to increase dissemination of cancer information. (long term)
9. Help population-based cancer registries achieve compatibility with the NCI SEER (Surveillance, Epidemiology, and End Results) Program, with the intent of improving data quality nationwide. (long term)
10. Expand the scope of the current NCI agreement with rural and isolated community and migrant health centers to provide health professionals with online access to relevant and timely information such as the Physicians Data Query. (medium term)
11. Institute a clearinghouse within Federal health agencies to provide current and comprehensive information on cancer prevention and therapy. (long term)
12. Reassess ongoing program efforts, specifically of the NCI and the National Institute on Aging, inferring, from available data, activities required to meet the cancer-related needs of older individuals. (medium term)
13. The aforementioned Institutes and the Veterans Administration, in cooperation with minority community leaders, should plan, develop, and target programs to address cancer needs of older minority individuals. (medium term)
14. Identify in these programs the factors and the age-related changes in health status that influence the interpretation of statistical data obtained for cancer deaths and overall mortality in the older minority population (e.g., statistics on elderly minority females may be skewed because of inaccuracy of birth certificates; little medical history may be recorded for recent immigrants). (long term)

15. Promote and assist in the development of a network among cancer intervention researchers. (medium term)

## **CANCER**

### **Goal VIII: Research**

Fund and conduct research concerning cancer etiology, prevention, risk reduction, screening, and therapy for minority populations and subgroups. (Secretary's Task Force Recommendation 8)

#### ***Objectives***

1. Define, develop, and implement the results of cancer studies that apply basic research to the problem of cancer etiology within specific minority groups. (medium term)
2. Develop, obtain support for, and implement a national initiative to reduce mortality from lung, prostate, breast, and cervical cancers. Target a segment of this program to specific racial and ethnic minorities. (medium term)
3. Assign research programs to address identified areas of high cancer incidence in minority populations. (medium term)
4. Continue research to improve early detection methods. (long term)
5. Support research on the screening needs of older individuals. (medium term)
6. Conduct demonstration projects in minority communities to determine how to bring screening technology to women at risk. (medium term)
7. Study minority rehabilitation, behavioral modification, pain, depression, and other variables in relation to biomedical aspects of cancer research. (short term)
8. Encourage pharmaceutical companies and cancer investigators to include minority cancer patients in cancer studies in proportion to minority incidence of the tumor type. (long term)
9. Actively recruit valuable minority patients in cancer clinical trials and assess results. (short term)
10. Study anticancer drugs in minorities, focusing particular investigations on cancer sites in which minorities have a higher incidence of cancer. Study should include pain, rehabilitation, and behavior modification methods. (long term)
11. Promote the performance of autopsies of cancer deaths to provide more accurate assessments of causes of death. Report such information to agencies responsible for compiling vital statistics. (short term)



# Cardiovascular Disease and Stroke

## CARDIOVASCULAR DISEASE AND STROKE: Strategic Goals and Objectives

### Goal I: Outreach

Develop, target, and expand outreach programs to inform and reinforce healthful behavior related to the prevention and treatment of cardiovascular disease and stroke (CVDS). Design programs appropriate for specific risk groups, populations, and subgroups of these populations. Communicate messages that meet the special needs, learning styles, behaviors, and attitudes of divergent minority groups, ages, and socioeconomic backgrounds. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Improve methods to overcome denial of personal risk factors. Focus on attitudinal and behavioral change rather than on passive information dissemination. (short term and continuing)
2. Assess the CVDS behavior modification and health information needs of minority groups and subgroups. Give special attention to minority youth, their families, and communities. (short term)
3. Based on identified needs, develop culturally relevant and educationally appropriate health promotion and disease prevention strategies. Approaches should include minority-specific media and education projects at the worksite, churches, schools, and senior centers and with other community-based organizations. (short and medium term)
4. Encourage educators and professionals from all sectors to increase the minority information content of health professions conferences, seminars, and other forms of continuing education. (short term)
5. Target minority subgroup communities for pilot outreach activities. (medium term)

## CARDIOVASCULAR DISEASE AND STROKE

### Goal II: Patient Education

Encourage health professionals to develop and disseminate culturally relevant and behaviorally effective patient education materials. Health professionals serving minority populations should begin to communicate information about risk factors and healthful behaviors at the earliest possible age. (Secretary's Task Force Recommendation 2)

#### *Objectives*

1. Increase professional awareness of the special problems associated with CVDS morbidity and mortality among minorities. Train health



professionals in counseling techniques that stress benefits of risk factor intervention. Take account of other nonhealth priorities that may affect a person's behavior, such as family issues, work, housing, income, or transportation problems. Also consider readiness levels in choosing times to emphasize preventive messages. (short term)

2. Assess existing minority health education communications for clarity, comprehensiveness, accuracy, and cultural relevance. Analyze the relative effectiveness of mass media, commercial advertising, audiovisual media, and community organization. (short term)
3. Collaborate with governmental and private minority organizations to develop new educational materials where needed. Reinforce risk avoidance messages. (short and medium term)
4. Disseminate culturally appropriate, multilingual information on CVDS excess morbidity and mortality among minority populations to health care providers. Help health care providers distribute and explain information to minority patients. Expand the use of grand rounds in minority health issues. Stress the role of nutrition. (short term and continuing)
5. Assess CVDS health educational information offered through community leaders, churches, schools, worksites, and voluntary agencies to determine how and why different approaches affect minority acceptance of prevention messages. (medium term)
6. Advocate changes in radio, television, and video content to stop glamorizing risk-taking behavior. (short term)
7. Work with fast food chains and food producers and distributors to promote healthful dietary alternatives. (short term)
8. Identify high-priority factors that cause distrust and discourage minorities from participating in prevention and promotion programs. (medium term)
9. Apply assessment data in designing programs for minority communities. Identify and use incentives for minority program acceptance. Assess the effects of community participation in program planning. (medium term)
10. Publicize successful community-based Federal agency health promotion programs as models for other minority CVDS health promotion activities. (medium term)

## **CARDIOVASCULAR DISEASE AND STROKE**

### **Goal III: Health Care Delivery and Financing**

Enhance methods to inform minority individuals about eligibility and benefits under Medicare/Medicaid programs and other public and private health care financing alternatives. (Secretary's Task Force Recommendation 3)

#### **Objectives**

1. Improve methods to educate minority beneficiaries and health professionals about Medicare/Medicaid eligibility requirements, methods of obtaining services, procedures for filing acceptable claims, and alternative public and private health financing options. (short term)
2. Encourage Federal and State programs to develop and disseminate culturally sensitive materials regarding available health care resources and

financing for minorities. Involve minority representatives in developing information diffusion strategies. (short term)

3. Reform Medicaid and Medicare national policies to eliminate barriers to optimal health care for CVDS. Include coverage for preventive and health promotion services. (short term)
4. Encourage cooperation among State Insurance Commissions, private insurers, and other health care financing organizations to expand coverage for prevention and health promotion services related to CVDS. (medium term)

## **CARDIOVASCULAR DISEASE AND STROKE**

### **Goals IV and V: Federal and Private Health Professions Education**

Develop programs and other collaborative activities among the Federal Government and educational institutions serving minorities. Increase the number of well-trained, culturally sensitive health professionals available to serve minorities. (Secretary's Task Force Recommendations 4 and 5)

#### ***Objectives***

1. Adequately fund minority health professions educational institutions. (medium term)
2. Train an appropriate balance of primary care and specialty health professionals in minority CVDS. (short term)
3. Initiate collaborative efforts among professional education institutions. Provide improved information on Federal professional training programs. Assist minority students in identifying their career preferences in health professional education, and counsel candidates in how to finance their education. (medium term)
4. Collaborate in developing CVDS curriculum for medical schools, CME, and other training organizations as they relate to minority populations. Take into account minority demography in the selection of training sites. (medium term)
5. Facilitate joint sponsorship of conferences, seminars, workshops, and meetings of voluntary organizations and professional associations. Focus on the need for health personnel trained in minority health promotion and treatment programs. (medium term)
6. Continue to support Federal programs to increase the number of minority and nonminority biomedical researchers investigating minority CVDS. (medium and long term)
7. Introduce minority students to health careers and other opportunities in the biomedical sciences from elementary school through graduate training. Assist students in deciding to pursue health careers despite the financial rewards of competing career choices. Provide education programs for teachers, counselors, and administrators to aid in recruitment of minority students into health science careers. Identify factors that discourage minorities from pursuing the health sciences and health professions and biomedical research careers, and develop strategies to eliminate these factors. (medium and long term)

8. Target minority students who are having difficulty competing or who are at risk of failure. Fund and assist them. (Funding is readily available for those who excel, but scarce for those who merely do well.) (immediate)
9. Develop university and college assistance programs to help retain minority students in the health professions. (short term)
10. Aid minority communities in attracting and retaining health professionals. Incentive programs should be reexamined as well as loan forgiveness fellowships. (long term)
11. Increase the numbers of health professionals practicing in minority communities by making Medicaid and Medicare payments competitive with payments from private insurers. (short term)
12. Draw on the resources and energies of private and voluntary organizations and businesses in minority communities to develop interventions to reduce CVDS risk factors. (medium term)
13. Provide Medicaid and Medicare coverage for preventive and educational services. (immediate)
14. Improve efforts to involve the full range of private, voluntary, and business organizations in implementing governmentally supported community interventions. (medium and long term)
15. Develop a strategy to stop inner-city hospital bankruptcy due to uncompensated care and disproportionately high malpractice premiums. (medium term)

#### **CARDIOVASCULAR DISEASE AND STROKE**

##### **Goal VI: Building Private and Community Resources (Secretary's Task Force Recommendation 6)**

See CDVS sections I through VIII, which address various specialized community-based resource development activities.

#### **CARDIOVASCULAR DISEASE AND STROKE**

##### **Goal VII: Data**

Improve surveillance data on the prevalence of risk factors for CVDS among minority populations and reassess minority risk factors through longitudinal prospective studies of selected risk factors in specific minority populations. Identify minority CVDS risk profiles and develop culturally sensitive multiple risk factor reduction approaches. (Secretary's Task Force Recommendation 7)

##### **Objectives**

1. Assess epidemiologic data for each minority group to identify the prevalence and pattern of traditional risk factors, such as elevated cholesterol. (long term)
2. Initiate research to identify and characterize less firmly established risk factors and their contribution to CVDS among minorities. (long term)
3. Develop current, detailed data on the prevalence, incidence, and mortality from CVDS and suspected risk factors for each minority subpopulation group. (long term)



4. Make better use of the available data on cardiovascular and cerebrovascular health status in minorities. Accelerate analysis of this information and streamline the process of gaining access to the data. (short term)
5. Design survey methodologies appropriate to minority populations. Ensure that programs effectively reach a representative sample. (short term)
6. Implement multidisciplinary cooperative surveillance of CVDS risk factors among minorities. (medium term)
7. Analyze surveillance data to define the groups at high risk due to factors such as hypertension, smoking, elevated cholesterol, lack of exercise, obesity, and poor nutrition. (long term)
8. Develop surveillance data gathering approaches appropriate to specific communities. (short term)
9. Develop multilingual approaches and culturally sensitive communications methods for survey research. (short term)
10. Continuously refine data on subpopulations, categorized by national origin, as new groups of immigrants emerge. Distinguish Black, Hispanic, and Asian data by ethnic origins—for example, Black American versus Caribbean and African origins; American-born Asian populations versus those of recent Chinese, Japanese, Philippine, Korean, Southeast Asian, Indian subcontinent, and Pacific Island origins; and American-born Hispanics versus those of recent Mexican, Puerto Rican, Cuban, Salvadoran, Guatemalan, and other subgroups of immigrants. (medium term and ongoing)

## **CARDIOVASCULAR DISEASE AND STROKE**

### **Goal VIII: Research**

Conduct research on behavioral and genetic risk factors for CVDS among minorities. (Secretary's Task Force Recommendation 8)

#### ***Objectives***

1. Identify genetic factors responsible for hypertension and premature atherosclerosis through study of phenotypic characterization of family pedigrees from selected minority groups. Identify genetic markers in families with several generations of disease history. (long term)
2. Involve minority health organizations and practitioners in the early stages of identification and characterization of families whose pedigrees would form the basis of these studies. (medium term)
3. Increase the number of lipid and lipoprotein measurements in minority groups to permit statistically significant analysis, which reflects the socioeconomic diversity of these groups and takes into account other factors known (or believed) to affect lipid levels. Initiate large-scale prospective studies to ascertain rates and types of dyslipoproteinemias and their relationship to the development of coronary heart disease. (medium term)
4. Ensure that minorities are oversampled in health interview surveys relating to CVDS and risk factors. (short term)

5. Study minority populations to identify the role of culturally related nutritional factors in the etiology, prevention, and treatment of CVDS. (medium term)
6. Identify appropriate dietary change approaches based on dietary patterns and culture-specific preferences, with priority given to research on weight reduction and control programs that are effective and acceptable to minorities. (medium term)
7. Increase communication between research and technology transfer programs. (short term)
8. Evaluate outcomes of outreach educational efforts for specific minorities. (long term)
9. Target communities and assess their characteristics, levels of awareness, behavior patterns, and use of medical and social services with reference to CVDS. (medium and long term)

# DIABETES

## DIABETES: Strategic Goals and Objectives

### Goal I: Outreach

Encourage development of outreach programs to disseminate information and educate minorities about their risk for diabetes and its complications, recognition of signs and symptoms, and methods of prevention and early diagnosis. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Reduce the number of minority persons with undiagnosed diabetes through screening of high-risk populations, and provide appropriate followup care. (short term)
2. Identify special information and communications needs of minority populations and subgroups of these populations. Improve existing and/or develop new education and training materials and programs for both minority persons and their health care providers. (medium term)
3. Educate both minority persons and providers who serve them about the importance of normal weight maintenance and prevention of obesity. (medium term)
4. Improve access to nutritional counseling that is sensitive to cultural preferences regarding foods, value systems (e.g., body image), and other unique features of minority populations. (medium term)
5. Provide nutrition education programs in the public schools for both students and food preparation personnel. (medium term)

## DIABETES

### Goal II: Patient Education

Develop and apply culturally relevant communications strategies to inform minority patients about the risks of diabetes, its complications, and available ways to prevent or control those conditions. (Secretary's Task Force Recommendation 2)

#### *Objectives*

1. Educate minority patients with diabetes and their health care providers about the importance of early detection and management of renal disease. (short term)
2. Educate minority patients with diabetes and their providers about the importance of CVD risk assessment and risk reduction. (short term)
3. Educate all minority individuals with diabetes and their providers about lower extremity problems and the necessity of self-care for these problems. (short term)

4. Develop strategies for reaching appropriate target groups to educate minority patients about dental care for the prevention of periodontal disease. (short term)
5. Educate pregnant minority women and their health care providers about screening for and the risk of gestational diabetes. (short term)
6. Educate minority women with diabetes and their health care providers about diabetes control prior to conception and throughout the prenatal and perinatal periods. (short term)
7. Educate minority patients and their health care providers about the importance of eye examinations. (short term)
8. Educate minority patients and their providers about early detection and management of renal disease. (short term)
9. Educate minority patients with diabetes and their providers about the importance of early detection and management of hypertension, based on the recommendations of the National Heart, Lung, and Blood Institute Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. (short term)
10. Educate minority patients with diabetes and their health care providers about the importance of detection and management of diabetic neuropathy. (short term)

## **DIABETES**

### **Goal III: Delivery and Financing Health Services**

Ensure that minority persons at risk for or diagnosed with diabetes receive the highest and best quality of preventive and therapeutic services, regardless of the persons' economic status or geographic location. (Secretary's Task Force Recommendation 3)

#### **Objectives**

1. Improve all available methods for informing minority individuals (both patients and health care deliverers) about eligibility and benefits under Medicare and Medicaid programs. (short term)
2. Improve access to highly qualified health care providers and, when necessary, promote referral of minority patients to appropriate facilities with adequate resources. (short term)
3. Improve the quality of available services and resources at the sites most heavily used by minority patients with diabetes. (short term)
4. Encourage third-party payors to reimburse for routine examinations, procedures, and preventive strategies recommended for prevention and management of *each* of the complications of diabetes. (short term)

## **DIABETES**

### **Goals IV and V: Developing Federal and Non-Federal Strategies**

Ensure that health professionals working with minorities with diabetes are available and accessible and that they are able to deliver state-of-the-art care within a multicultural environment with diverse communications needs. (Secretary's Task Force Recommendations 4 and 5)



### ***Objectives***

1. Implement existing guidelines for care, using strategies that are culturally relevant, address specific problems of minorities, and identify barriers to effective health care delivery to minorities with diabetes. (medium term)
2. Improve access to existing and develop new programs for the education and training of primary care providers in the diagnosis, treatment, and timely referral of minority patients at high risk for diabetes and any of its complications. (short term)
3. Identify health care professionals who are currently serving minorities and explore ways to increase this group, including evaluation of current Federal and private efforts. Improve training of increased numbers of underrepresented minorities. (short term)
4. Ensure that government-sponsored commodity programs and school lunch programs are consistent with recommended guidelines for good nutrition. (short term)

## **DIABETES**

### **Goal VI: Building the Capacity of the Non-Federal Sector**

Improve the system of diabetes prevention, treatment, and control through enlisting, empowering, and coordinating coalitions of Federal and local health and civic organizations. (Secretary's Task Force Recommendation 6)

### ***Objectives***

1. Involve the private sector in Federal efforts to accomplish the goals and objectives of strategies for improving minority health. (short term)
2. Develop, maintain, and evaluate the utilization of a database of minority programs and resources. (short term)
3. Involve minority community representatives in the planning and implementation of community programs of prevention, education, screening, diagnosis, and treatment of diabetes and its chronic complications. (immediate)

## **DIABETES**

### **Goal VII: Data**

Develop a minority health diabetes database for use in epidemiologic, scientific, demographic, economic, and health services research and analysis. (Secretary's Task Force Recommendation 7)

### ***Objectives***

1. Assess available minority health diabetes databases and identify and facilitate correction of deficiencies. (short term)
2. Identify OMH as the responsible agency for coordinating the collection and organization of minority health data, including publication of periodic special reports. (short term)
3. Improve the collection and analysis of health data to ensure that the data will enable a measurable assessment of progress. (medium term)

4. Ensure that racial/ethnic identifiers are included in minority health databases and that there is oversampling of selected minorities in national surveys. (medium term)

## **DIABETES**

### **Goal VIII: Research**

Improve knowledge of the prevention, diagnosis, management, and control of diabetes and its complications in minorities. (Secretary's Task Force Recommendation 8)

#### ***Objectives***

1. Increase basic and clinical research related to the etiology and pathogenesis of diabetes and its complications, and, as appropriate, develop clinical trials and community and family studies to assess specific opportunities for intervention and improved management and prevention of diabetes and its complications in high-risk minority populations. (continuing)
2. Collect scientifically based data that will allow the definition of race and ethnic-specific criteria for obesity. (medium term and continuing)
3. Establish mechanisms and conduct clinical trials for primary prevention of diabetes in minority communities. (medium term and continuing)
4. Establish mechanisms for and conduct clinical trials for primary prevention of macrovascular complications by reduction of CVD risk factors. (medium term and continuing)
5. Encourage research in clinical trials to reduce the impact of diabetic end stage renal disease in minority communities. (medium term and continuing)

# HIV/AIDS

## HIV/AIDS: Strategic Goals and Objectives

### Goal I: Outreach

Develop and implement a comprehensive outreach program of AIDS information and risk reduction counseling for the segments of minority communities at risk for HIV infection.

#### *Objectives*

1. Disseminate concepts for designing and implementing HIV/AIDS prevention education programs for racial and ethnic groups and subgroups, with consideration for regional differences. (continuing)
  - a. Develop HIV/AIDS prevention education programs that target racial and ethnic minorities in both urban and rural settings. (immediate)
  - b. Recruit community leaders and representatives of the target populations (i.e., HIV-infected persons) to plan, implement, and evaluate HIV/AIDS prevention education programs. (short and medium term)
  - c. Design culturally sensitive materials and information programs for self-identified racial and ethnic subpopulations that are at risk for HIV/AIDS, including lesbian/gay and bisexual people, intravenous and other drug users and their sexual partners, women of childbearing age, adolescents, and adults. (medium term)
  - d. Develop and disseminate educational messages that focus on the impact of HIV/AIDS on the entire community. (short and medium term)
2. Develop multimedia campaigns that continuously disseminate culturally appropriate messages with positive peer role models on posters, videotapes, music and other audiocassettes, billboards, and television and radio broadcasts. (short term)
  - a. Use existing communications channels in the minority community, the religious community, minority-targeted media outlets, health clinics, day care centers, and congregation points such as shopping centers, recreational centers, beauty shops, clubs, and bars. (short and medium term)
  - b. Develop and disseminate educational messages that address sociocultural misconceptions about HIV infection and AIDS as well as barriers to risk reduction. (short term)
  - c. Include referrals to other sources of information in educational messages for all target groups. (short term)
  - d. Expand promotion of the use of Federal AIDS information resources such as the AIDS Information Clearinghouse and other national

- sources of related information, and include language appropriate to the region and specified community. (medium term)
3. Develop and disseminate strategies and materials that reflect the sociocultural and language needs of all minority groups and subgroups at specific sites, including but not limited to the following: (short and medium term)
    - a. Support school-based HIV/AIDS peer education components that provide information that enhances self-esteem and builds interpersonal and communications skills related to community issues such as sexually transmitted diseases (STDs), teenage pregnancy, violence, and substance abuse. (short term and continuing)
    - b. Support HIV/AIDS education components designed for and with youth not in traditional learning settings, such as military and Job Corps recruitment centers, playgrounds, shelters for homeless and runaway youth, and migrant workers community settings. (short term and continuing)
    - c. Develop and implement programs for correctional institutions that provide culturally sensitive and language-appropriate HIV/AIDS information to all inmates and staff. (medium term)
    - d. Encourage unions and employers, especially in small businesses and minority-operated and owned businesses, to jointly sponsor worksite programs that stress HIV/AIDS risk reduction, including education to allay fears regarding transmission by casual contact. (immediate)
    - e. Develop and disseminate information targeted to migrant, immigrant, and undocumented persons in both urban and rural settings. (short term)
  4. Develop strategies to incorporate other existing community health concerns into AIDS educational messages. (short and medium term)
  5. Develop and disseminate educational messages that encourage protected behavior (e.g., use of clean needles, use of condoms, use of spermicide). (immediate)
  6. Provide more information on HIV antibody testing and the advantages of early diagnosis and treatment for women and men. (immediate)

## **HIV/AIDS**

### **Goal II: Patient Education**

Provide the full spectrum of culturally and personally appropriate HIV/AIDS health information to minority patients involved in health care delivery systems.

#### **Objectives**

1. Incorporate HIV/AIDS education components into federally supported health and social service programs such as drug treatment clinics, supplemental food programs, maternal and child health programs, and welfare. (immediate)
2. Use training curricula and other technical assistance materials to assist staff in State and local health and social services programs (e.g., planning clinics, maternal and child health programs, STD clinics, migrant health



- centers, and drug treatment services) for minority clients, and provide them with culturally sensitive and language-appropriate information and counseling. (medium and long term)
3. Develop a comprehensive program that promotes early HIV antibody testing, diagnosis, and early treatment intervention. (medium term)
    - a. Develop culture-specific HIV/AIDS educational materials that stress the benefits of early HIV antibody testing, diagnosis, and early treatment intervention. (medium term)
    - b. Develop and promote measures that ensure strict protection of confidentiality and cultural sensitivity in HIV antibody testing, counseling, and medical referral services. (short term)
    - c. Disseminate to HIV antibody testing sites measures that would require culturally sensitive pre- and posttest counseling for patients seeking these services. (medium term)
    - d. Develop and disseminate guidelines for counseling HIV-positive minority patients. (immediate)
  4. Develop realistic information that explains the seriousness of HIV infection and its impact on the lives of infected individuals and their support systems. (short term and continuing)
    - a. Develop and disseminate messages that inform patients about options to enhance their quality of life, and encourage them to participate in decisionmaking related to their own health care traditions. (short term)
    - b. Provide culturally relevant motivation and training in practical skills to help patients avoid reinfection and spread of HIV/AIDS. (short and medium term)

## **HIV/AIDS**

### **Goal III: Delivering and Financing Health Services**

Ensure that all minority patients with HIV infection, regardless of their socioeconomic status or place of residence, can access and utilize timely and quality medical care that is appropriate to their language and culture.

#### ***Objectives***

1. Expand the Federal role in supporting ambulatory care systems and community health centers in minority communities. (long term)
2. Assist low-incidence minority communities in planning HIV/AIDS health care services, and involve HIV-infected community people in the planning. (medium term)
3. Develop a plan to alleviate the impact of providing care for HIV/AIDS among large city public hospitals by providing financial incentives and support and distributing the burden of care among other facilities in the community. (short and medium term)
4. Ensure that at least one comprehensive medical facility is capable of providing culturally sensitive HIV-related services, including an organized outpatient program, in geographic areas with minority populations. (long term)

5. Support the development of programs for families, including support services such as transportation, income maintenance, housing and food assistance, mental health and psychosocial counseling, legal guidance to arrange for child custody in the event of a parent's death, therapeutic daycare centers, and education and support of survivors. (short and medium term)
6. Support projects to renovate and construct long-term care facilities for people living with AIDS in minority communities. (long term)
7. Develop a plan to address financial coverage for uninsured people with HIV infection.
  - a. Develop Medicaid standards of coverage and eligibility that are applied with impartiality throughout the country. (medium term)
  - b. Expand special HIV-related Medicaid coverage to include alternative services such as home health services and hospice care, incentives for hospitals and nursing homes to accept patients with AIDS, payment for case-management services, and waivers from requirements regarding home- and community-based care. (medium and long term)
  - c. Establish separate Medicaid diagnosis-related groups (DRGs) for AIDS patients or adjust the most frequently used DRGs to reflect the increased costs of HIV/AIDS care to encourage service providers to accept Medicaid recipients with HIV/AIDS. (medium and long term)
8. Publicize, broadcast, and disseminate changes in Medicaid policies among racial and ethnic communities. (short and medium term)
9. Institute Federal legislation related to the 1964 Civil Rights Act and other civil liberties legislation to prohibit discriminatory eligibility criteria that would deny health insurance coverage on the basis of membership in groups perceived to be at high risk for acquiring HIV infection or AIDS. (medium term)
10. Establish HIV-related testing, counseling, early intervention and treatment services, and facilities in correctional institutions. (short term)
  - a. Ensure nondiscriminatory policies and no quarantine of inmates.
  - b. Recruit, train, and monitor staff who are aware of HIV/AIDS and its impact.
11. Enact policies to ensure the provision of culturally appropriate care to HIV-infected patients who are entitled to Veterans Administration benefits. (short term)
12. Promote the development and evaluation of models that assess the costs and service utilization needs for the various clinical stages of HIV infection among minority populations in different geographic locations. (short and medium term)
13. Establish a comprehensive, long-range plan to address critical HIV/AIDS service gaps such as housing options, home health nursing and attendant care, child care, psychosocial and legal services, mental health services, dental care, and hospice services. (medium term)
14. Develop drug treatment services that are specifically designed for minority HIV-infected clients, including treatment on demand. (short term)

15. Assist minority communities to provide a continuum of culturally sensitive and language appropriate care to minority people who are HIV infected, which will integrate case management, financing, and multidisciplinary health care teams as well as representatives of nontraditional health care and alternative therapies. (short term)

## **HIV/AIDS**

### **Goals IV and V: Health Professions Development; Developing Federal and Non-Federal Strategies**

Ensure an adequate supply of health professionals, including a higher percentage of women, with specialized training and cultural and language sensitivity to the issue of HIV infection among racial and ethnic groups, as well as to women's health issues.

#### ***Objectives***

1. Support projects that provide culturally sensitive support services, such as counseling, tutoring by peers as well as educators, group study programs, and parental involvement, to help minority students graduate from high school and college. (short term and continuing)
  - a. Support outreach programs that provide information on college admissions requirements and financial aid options to minority students in junior high school. (immediate)
  - b. Support the establishment of magnet schools or enrichment programs that encourage high school and college students to pursue careers in health sciences through special courses and activities, such as summer research opportunities and internships. (immediate)
  - c. Encourage college transition programs that are designed to increase the academic qualifications of minority students. (immediate)
  - d. Provide financial incentives to encourage minority students who want to pursue health careers. These incentives may include scholarships, grants, and Federal, corporate, and private endowments and internships. (immediate)
  - e. Devise strategies to ensure the maintenance of campus environments that are hospitable to minority students. Activities could include establishing more academic support units for minority students, integrating culturally relevant content into curricula, and assuring more tenured administrators, faculty, and trained residence hall advisers who can deal with cultural, linguistic, and sexual diversity and prejudice. (short and medium term)
3. Provide financial incentives to institutions that excel in recruiting and training minority health professionals. (short term)
4. Encourage institutions that recruit and train minority health professionals to develop relationships with their community. These relationships should emphasize responsiveness to community needs and should enable the institution to serve as a role model for its students. (short term and continuing)
5. Provide more Federal scholarships to medical students in return for agreement to practice in public health care facilities in minority



communities, especially those facilities serving HIV/AIDS patients. (short term)

6. Encourage medical schools and training programs to develop curriculum to change racial and ethnic prejudices as well as negative attitudes toward the poor. (short term)
7. Support projects that demonstrate successful pluralistic health delivery systems appropriate to the values and preferences of different social classes and ethnic groups. These systems should focus on reducing the social distance between the patient and provider. (medium term)
8. Encourage medical schools and training programs (regardless of setting) as well as continuing education programs for health care providers to supplement and expand existing educational programs to include issues regarding primary care for minority patients with HIV/AIDS. (short and medium term)
9. Support the involvement of minority psychologists, counselors (including chemical dependency counselors), social workers, and other psychosocial and mental health care providers through enhancement of HIV-related knowledge in their college/graduate school curricula, continuing education units, and professional conventions. (short and medium term)
10. Promote collaboration of professionally trained multicultural educators with counselors, therapists, and other persons responsible for developing and providing culturally appropriate HIV-related care. (medium term)
11. Develop a cadre of multicultural and multilingual trained health care professionals. (short and medium term)
  - a. Expand federally funded technical assistance initiatives, such as providing minority speakers, resource persons, and workshop support to minority health professional organizations and community-based health care providers caring for minority patients.
  - b. Expand Federal funding for programs that disseminate research findings to health care providers serving minority communities.

## **HIV/AIDS**

### **Goal VI: Building the Capacity of the Non-Federal Sector**

Develop a cadre of multicultural and multilingual programs for AIDS prevention, diagnosis, treatment, and control.

#### **Objectives**

1. Encourage State and local health departments to coordinate and encourage programs of minority organizations that provide HIV/AIDS education, testing, and treatment for minority populations. (short and medium term)
2. Provide technical assistance to communities regarding the development, implementation, and evaluation of culturally relevant and sensitive programs. (short term)
  - a. Help providers in minority communities to expand their capacity by making effective use of existing resources, such as implementing a community- or statewide HIV/AIDS referral and followup system. (short and medium term)



- b. Provide technical assistance to help build capacity in areas such as personnel recruitment and retention, equipment acquisition and maintenance, strategic planning, data collection, and program evaluation. (short term)
3. Provide technical assistance to community-based programs to help obtain Federal and non-Federal funding, including techniques for preparing proposals and grant applications. (immediate)
4. Require minimal paperwork from community-based organizations receiving Federal funding. (short term)
5. Encourage Federal, State, and local funding sources to designate HIV/AIDS appropriations as a budget line item. (short and medium term)
6. Support projects to develop and evaluate AIDS information systems to collect and analyze minority-specific data for planning future surveillance as well as health care service use, cost, and financing. (medium and long term)
7. Help State and community-based programs develop a network of patient support systems for minority patients with HIV infection. Systems should include patient advocates, case managers, peer support groups, and other service providers. (medium and long term)

## **HIV/AIDS**

### **Goal VII: Data**

Develop and share a minority-focused AIDS database for use in epidemiologic research, biomedical research, and research concerning health care services delivery and financing. These data collection efforts should assure confidentiality and include key minority personnel.

#### ***Objectives***

1. Ensure that the language of instruments used to generate data is sensitive and appropriate for the cultures to which they apply, thereby avoiding cultural, ethnic, racial, and sexual orientation biases. (short and medium term)
2. Conduct supplemental surveillance studies among minority populations to evaluate increased morbidity and mortality not identified by current surveillance procedures and diagnostic practices. (medium and long term)
3. Collect HIV seroprevalence data in expanded samples of minority populations. (medium term)
4. Develop and evaluate effective methods for obtaining data. (short and medium term)
5. Monitor the impact of HIV-related health care delivery on the health care delivery system as it affects public hospitals and other delivery settings in minority communities. (short term)
6. Develop data collection systems to profile patients in federally funded clinical trials to track progress being made in minority patient accrual and to ensure confidentiality. (short and medium term)

7. Expand data regarding existing conditions, potential barriers, and future possibilities and develop strategies to increase involvement of minority patients and researchers in clinical trials. (short and medium term)

## **HIV/AIDS**

### **Goal VIII: Research**

Improve knowledge of the prevention, diagnosis, and management of HIV infection as it affects racial and ethnic minorities. Assure inclusion of minority persons in the prevention, diagnosis, research, and management of HIV infection.

#### **Objectives**

1. Extend natural history and epidemiologic studies of HIV infection and AIDS to incorporate a prominent focus on racial and ethnic groups. (long term)
2. Conduct more research to determine if socioeconomic factors contribute to the disproportionate impact of HIV infection on African Americans and Hispanics. (medium term and continuing)
  - a. Conduct studies of natural history and epidemiological trends among individual subgroups. (medium term)
  - b. Conduct research to clarify the natural history and epidemiology of HIV infection and AIDS associated with drug and substance use, focusing particularly on racial and ethnic differences and the transmission of HIV infection among drug users. (medium term)
3. Support studies that seek to improve methods for projecting future incidence of limited and focused AIDS cases among racial and ethnic populations. (short term)
4. Support studies of HIV-related illnesses and opportunistic infections to which minorities are particularly susceptible. (short term)
5. Conduct serial HIV/AIDS-related knowledge, attitude, and behavior surveys among racial and ethnic groups and subgroups. (medium term)
6. Expand epidemiological studies of heterosexually transmitted HIV infection. (medium term)
7. Conduct research to improve the diagnosis of HIV infection in newborns. (medium term and continuing)
8. Design surveys specifically to elicit information on crack, heroin, and other drug use and needle sharing practices among various racial and ethnic groups and subgroups, including adolescents. (medium and long term)
9. Design surveys specifically to elicit information on sexual behaviors among minority populations. (medium term)
10. Require federally funded clinical trials to develop and implement more strategies to recruit more minority patients and investigators. (short term)
11. Expand clinical trials that specifically investigate HIV infection in children and women. (short and medium term)
12. Establish more clinical trial units in locations serving minority populations. (short term)

13. Continue to examine ways to extend the reach of clinical trials to minority populations (e.g., establishing satellite units in drug treatment clinics; sponsoring cooperative work with community health centers, minority academic institutions, and city hospitals; and establishing community-based clinical trial units), with followup medical care, whether or not that care is directly related to the trials. (short term)
14. Develop parallel programs that allow access to experimental drugs by patients with HIV infection who do not qualify for, or are otherwise unable to participate in, clinical trials. (medium term)
15. Develop clinical trial protocols that specifically address the needs and concerns of minority populations, including studies of differences in drug response and of interactions of methadone with drug treatment for HIV-related conditions. (medium term)
16. Develop culturally sensitive and language-appropriate materials, such as patient orientation brochures and informed-consent affidavits, that address barriers to participation in clinical trials by racial and ethnic minority populations. (short and medium term)
17. Establish a network of minority principal investigators who are concerned with research related to HIV infection among racial and ethnic populations. (short term)





# Intentional Violence

## INTENTIONAL VIOLENCE: Strategic Goals and Objectives

### Goal I: Outreach

Develop and implement appropriate violence prevention and intervention strategies for all forms of intentional violence in minority communities. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Develop model methods to identify high-risk communities and groups with a predisposition toward violent behavior, and assist in early intervention. (medium term)
2. Identify victims, high-risk community groups, and families with histories of repeated violence perpetration or victimization. (short term)
3. Develop age-specific model multicultural curricula for use in schools from preschool to community college levels. Target children below the age of 8 in particular. (medium term)
4. Report to health officials all cases of observed abuse (e.g., abuse observed by school nurses, emergency room personnel, social service workers, clergy, and neighbors). (short term)
5. Develop a model child witness policy for use by law enforcement officials, other community agencies, and the criminal justice system to reduce the incidence of minors being exposed to the aftermath of violent behavior and to traumatic courtroom proceedings. (medium term)
6. Develop guidelines for community agencies to use in counseling programs for minors and others who are witnesses to violence or who are themselves victims and/or survivors. Provide resources to assist communities to develop an inventory of existing programs. (medium term)
7. Provide technical assistance and training in writing proposals, developing intervention evaluation components, etc. As part of this assistance, involve private funding sources. (medium term)
8. Assist communities in identifying resources and technical expertise to develop prevention strategies at the local level. (medium term)
9. Examine continuing developments such as parapolice, new drugs, and different patterns of violence as they quickly evolve. Refine strategies in light of new developments. (immediate and continuing)
10. Fund outreach professionals to mobilize community response. (medium term)
11. On police calls of domestic disturbances, or when a victim of abuse seeks medical care, screen other members of the household (especially children) for possible victimization and consider them to be "at risk."

Provide information about any available services for violence prevention.  
(short term)

## **INTENTIONAL VIOLENCE**

### **Goal II: Community-Based Education**

Educate minority communities about risk factors and possible preventive measures to control violent behavior. (Secretary's Task Force Recommendation 2)

#### ***Objectives***

1. Develop model surveillance and followup procedures to report suspected violence incidents to appropriate agencies for intervention. Maintain strict confidentiality and consider other factors such as involvement of alcohol or other drugs. (short term)
2. Develop culturally specific guidelines for mentor programs (such as Big Brothers) for different sex and age groups and different histories of violence. (short term)
3. Develop culturally specific guidelines for parenting/nurturing programs for different sex and age groups and for different circumstances of violence. (short term)
4. Survey public attitudes and target populations needing information about minority population-related violence, violence prevention programs, and public support of programs and activities. (short term)
5. Inform minorities and recently arrived immigrants, refugees, and undocumented populations of violence reduction methods. Consider these groups to be at elevated risk for victimization and later perpetration of violence. (medium term)

## **INTENTIONAL VIOLENCE**

### **Goal III: Delivery and Finance**

Expand and improve the overall coordination of minority population-related violence prevention programs in the Government and private sector. (Secretary's Task Force Recommendation 3)

#### ***Objectives***

1. Define the role OMH should play in coordinating minority population-related violence prevention programs throughout the Federal Government. (medium term)
2. Expand and improve the current OMH coordinating role for minority population-related violence prevention issues and programs within the PHS and all DHHS agencies. (short term)
3. Define the role OMH should play in coordinating minority population-related violence prevention efforts of State and local governments and private sector entities. Provide information about the availability of private and public funds for violence prevention. (medium term)
4. Provide a minority violence prevention resources list of technical assistance and funding information. Establish regional teams to assist local governmental agencies and minority population communities and coalitions. (medium term)

## **INTENTIONAL VIOLENCE**

### **Goals IV and V: Federal and Non-Federal Health Professions Education**

Sensitize physicians, emergency room personnel, teachers, counselors, and others who encounter people with intentional injuries to the appropriate ways to counsel victims and to identify the perpetrators of violence who are at high risk for repeated violence or eventual homicide. (Secretary's Task Force Recommendations 4 and 5)

#### ***Objectives***

1. Develop education and training modules, with an emphasis on minority ethnic and cultural issues, for health professionals and others likely to be involved in violence prevention activities. (short term)
2. Train medical and social work personnel and police officers in sensitively handling victims of violence. This training should be a mandatory component of medical and other professional training curricula, as well as of continuing education. (medium term)
3. Provide training curricula for individual groups, medical professionals, health workers, school personnel, social agency personnel, and community leaders. (short term)
4. Advocate violence prevention initiatives as a routine part of State, municipal, county, and other programs where community-based coalitions could have an influence on prevention. (short term)
5. Provide scholarships and fellowships to minority baccalaureate, master's degree, and graduate students who have an interest in studying violence prevention and a commitment to the minority community. Monitor career paths and provide incentives to encourage multidisciplinary involvement in violence prevention. (medium term)
6. Develop undergraduate violence prevention curricula that allow students to major in subjects such as violence prevention psychology and violence prevention social work. (medium term)
7. Develop violence prevention internships with students rotating through relevant organization assignments, such as police agencies, hospitals, social agencies, psychology practices, and VISTA programs. (medium term)

## **INTENTIONAL VIOLENCE**

### **Goal VI: Data**

Develop a research database to allow investigators to identify and develop control methods for the major factors affecting minority community violence and homicide. (Secretary's Task Force Recommendation 7)

#### ***Objectives***

1. Design, implement, and maintain a central data bank on all federally funded programs related to minority population-related violence. (medium term)
2. Develop a national database to prioritize violence prevention programs and to identify needs for minority violence research. (long term)



3. Share information among all organizations in the violence prevention field. (short term)
4. Compile an inventory of existing violence prevention programs and strategies, and evaluate their effectiveness for minority populations. (medium term)
5. Develop trauma registries incorporating demographic, epidemiologic, clinical, and psychological data related to incidents of violence. (medium term)
6. Compile an inventory of existing prevention and surveillance programs that identify at-risk individuals and groups. Evaluate surveillance programs that relate previous history of victimization data to data concerning perpetrators of violence. (medium term)

## **INTENTIONAL VIOLENCE**

### **Goal VII: Research**

Develop a national research agenda to identify the nature and scope of intentional violence in minority populations and to evaluate prevention and intervention strategies. (Secretary's Task Force Recommendation 8)

#### **Objectives**

1. Evaluate the replicability of existing, effective minority outreach approaches to violence prevention. Transfer successful strategies to other minority communities. (short term)
2. Develop a research program to study biological causative factors in violence (e.g., head injuries, prolonged substance abuse). (short term)
3. Study different patterns of violence among different minority groups to determine what influences the kinds and frequency of violent acts within subpopulations. (medium term)
4. Develop methodologies to evaluate different aspects of violence prevention-related factors, such as availability of firearms, peer influences, entertainment, movies, television, substance abuse, and familial dysfunction. (long term)
5. Study nonviolent, esteem building, alternative behaviors, such as problem resolution and emotional stress reduction. Develop methods to teach at-risk groups appropriate and personally acceptable behavioral alternatives to violence and abuse. (long term)



# Infant Mortality

## INFANT MORTALITY: Strategic Goals and Objectives

### Goal I: Outreach

Reduce the rate of unintended pregnancies and assure equal access to methods of limiting pregnancies among minority populations through outreach and education programs. Provide a continuum of reproductive health services from preconception to postnatal care for high-risk women. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Identify high-risk young women and the factors that influence their use of pre-pregnancy and prenatal health care services. (medium term)
2. Develop culturally sensitive multilingual programs to increase minority use of pre-pregnancy and prenatal health care services. (long term)
3. Expand the content of health education to emphasize personal reproductive responsibility and to appropriately assist minorities in adapting healthful reproductive behaviors. (short term)
4. Increase knowledge of the relative benefits and risks of different fertility-regulating methods. Clearly target both men and women at risk for unintended pregnancies or HIV infection. (medium term)
5. Promote and monitor access to public and private services that help minority persons regulate their fertility, particularly adolescent men and women. (long term)
6. Educate minority men and women about the relationship of HIV infection and risky reproductive behaviors. Emphasize the dangers to the parents and to the unborn and newborn. (immediate)

## INFANT MORTALITY

### Goal II: Patient Education

Develop programs to inform men and women of healthy reproductive behaviors before, during, and after pregnancy. Disseminate information and replicate successful programs. (Secretary's Task Force Recommendation 2)

#### *Objectives*

1. Develop minority education campaigns about health risks before, during, and after pregnancy. Use appropriate minority role modeling techniques. (medium term)
2. Expand provider and patient education regarding risk assessment and appropriate treatment responses to problematic pregnancies. (short term)
3. Offer and evaluate smoking cessation programs for pregnant women and their partners. (short term)

4. Integrate and evaluate risk reduction comprehensive counseling and support services. Stress employment, transportation, child care problems, and other risks. (medium term)
5. Develop and evaluate risk reduction case management programs to help minority families avoid postneonatal health problems. Replicate successful programs. (long term)
6. Evaluate current training programs in patient communications. Also assess support group approaches for parents of high-risk infants. (short term)
7. Develop and implement a comprehensive program for risk groups. Include information, education, counseling, and testing about AIDS. (long term)

## **INFANT MORTALITY**

### **Goal III: Delivery and Financing**

Eliminate barriers to the use of reproductive health care, including prenatal, perinatal, pregnancy, and postnatal health services. (Secretary's Task Force Recommendation 3)

#### ***Objectives***

1. Incorporate pregnancy planning services in programs of ongoing general health care. (short term)
2. Make available and reimburse costs of antepartem and postpartem assessment tests for minority women. (short term)
3. Expand the availability of prenatal screening for conditions that affect the neonate, such as hepatitis B and inherited disorders. (medium term)
4. Increase eligibility and expand the size of the insured pool of children and pregnant women, through public and private means. (medium term)
5. Institute interstate Medicaid eligibility for migrant workers and their children. (medium term)
6. Use Early Prevention Screening, Detection, and Diagnosis Test (EPSDT) programs to provide comprehensive preconception, prenatal, and maternity care to adolescents. (long term)
7. Have States expand presumptive eligibility for prenatal, perinatal, and postnatal Medicaid. Expand coverage for all medical procedures for pregnant minority women. (medium term)
8. Improve physician participation in Federal health care programs through means such as improving claims processing and changing reimbursement amounts. (medium term)
9. Provide technical assistance to State Title V agencies and other maternal and child health providers interested in trying innovative financing and delivery approaches. (long term)
10. Continue to monitor changes in expanded eligibility in programs such as CHAP concerning characteristics of new eligibles, participation rates, use patterns, costs of care, and outcomes. Assess State efforts to inform potential new eligibles of changes in Medicaid. (long term)

## **INFANT MORTALITY**

### **Goals IV and V: Federal and Non-Federal Health Professions Education**

(No objectives were formulated. Please see Chapter III, "Health Professions," of the overall strategic plan.)

## **INFANT MORTALITY**

### **Goal VI: Building Non-Federal Resources**

Expand the capability of State and private health care systems to provide comprehensive pre-pregnancy, perinatal, post-pregnancy, and infant health care services to minorities. (Secretary's Task Force Recommendation 6)

#### ***Objectives***

1. Expand prenatal care benefits, regardless of type of provider, to include other services such as prenatal vitamins, expanded nutrition supplements, psychosocial and health education services, and childbirth education classes. (short term)
2. Eliminate arbitrary limits to coverage of prenatal health care for minority women in both public and private sources of funding. (long term)
3. Expand injury prevention programs for infants in areas such as automobile safety and fire protection. (short term)
4. Encourage States to apply for Medicaid waivers to test the cost-effectiveness of the case-managed system of care for pregnant women and their children. (long term)
5. Encourage and evaluate innovative State models of comprehensive prenatal care and consider replication of successful programs. (long term)
6. Continue to encourage, regionalize, and coordinate health care and refer high-risk women for delivery in the appropriate level of care. Improve the capability of level I and level II hospitals to manage obstetric emergencies and deal with the transport of pregnant women and sick infants. (long term)
7. Identify possible mechanisms for moderating physician liabilities from birth-related suits. (long term)
8. Develop information systems to identify which health care providers do and do not accept mothers and infants with Medicaid eligibility. (short term)
9. Set up a task force to assess impact on minorities of current State approaches to managing uncompensated care. (long term)
10. Analyze cases of infant death in areas with high or changing infant mortality rates to identify health services problem areas. (short term)

## **INFANT MORTALITY**

### **Goal VII: Data**

Ensure that all data collection includes the information necessary to examine the known and suspected biomedical and socioeconomic factors influencing infant



mortality and low birthweight among minority populations. (Secretary's Task Force Recommendation 7)

**Objectives**

1. Encourage States to evaluate the quality of information on birth and death certificates to ensure accurate self-reporting. (long term)
2. Continue the National Linked Birth and Infant Death Database indefinitely. (long term)
3. Ensure accurate ways of recording subgroup ethnicity by self-report. Collect more detailed information on race and ethnicity of the mother and father. (long term)
4. Collect data on insurance coverage of pregnant women, on the average number of pregnant women eligible for and receiving Medicaid in a year, on when insurance coverage begins in pregnancy, on extent of coverage for components of care, and on age breakdowns in more detail. (medium term)
5. Ensure that special measures used for the national fertility surveys are expanded to facilitate research on minority groups and subgroups. (medium term)
6. Encourage additional studies such as the Mexico-U.S. border survey, which are valuable in their focus on special groups of high interest. (short term)
7. Institute several improvements in the National Natality and Fetal Mortality Followback Surveys. Goals for improving these data sources are to:
  - a. Evaluate 1988 changes and assess the utility of the new data on minorities.
  - b. Include defined and expanded categories of information on maternal complications and neonatal morbidity. (medium term)
8. Support the National Longitudinal Survey-Youth Cohort of the Department of Labor (NLSY). (short term)

**INFANT MORTALITY**

**Goal VIII: Research**

Increase knowledge of the factors influencing preconception, perinatal, postnatal, and maternal health for minorities. (Secretary's Task Force Recommendation 8)

**Objectives**

1. Study the components of prepregnancy, prenatal, perinatal, and postnatal care that are associated with improvements in birthweight and decreases in mortality. (long term)
2. Expand research on the factors associated with adolescent unplanned pregnancies and inadequate use of fertility-regulating techniques, particularly among adolescents. (long term)
3. Study how planning pregnancies influences prenatal care, birth outcomes, and infant well-being. (long term)
4. Expand research on the experiences, attitudes, and beliefs that affect minority women's use of continuing health care. (long term)



5. Expand research on the effects of nutrition on pregnancy outcome for different minority groups. (long term)
6. Study the effects of multiple alcohol, drug, and cigarette use on pregnancy outcome. (medium term)
7. Study birthweight differences and birthweight-specific mortality rates for minority groups to better understand the social, biological, acculturation, and environmental processes associated with low birthweight and the relationship of low birthweight to infant mortality among minorities. (long term)
8. Study fertility patterns, use of prenatal care, and perinatal and infant outcomes of Native Americans as they relate to ethnicity, geographic distribution, and cultural diversity. Include investigation of fetal alcohol syndrome and sudden infant death syndrome. (long term)
9. Encourage research on Asian American perinatal outcomes. Specific aims are to:
  - a. Better explicate the relationships between social, economic, demographic, biologic, acculturation, and behavioral characteristics and perinatal outcome in Asian Americans. (medium term)
  - b. Apply research to reduce disparities within the Asian American population and also to better understand ways to avoid adverse outcomes for other groups. (medium term)
  - c. Address problems of subgroups within the Asian population. (long term)
10. Investigate perinatal outcomes of Puerto Rican American incidence of low birthweight and their socioeconomic status, use of health care services, and patterns of movement back and forth to Puerto Rico. (long term)
11. Study the causes of postneonatal mortality, including the interrelationship of individual and familial behaviors, health care delivery factors, caretaker knowledge and practice of health behaviors, use of well and sick baby care, immunizations for babies, and sources of accidental death, such as risks associated with substandard housing. (long term)
12. Study the link between economic conditions and infant mortality to better understand the interplay between individual, financial, and structural factors. (long term)
13. Study the influence of racism and acculturation as well as stress and women's resources to deal with stress. (long term)
14. Study differences in maternal health as they relate to birth outcome, use of improved pregnancy dating techniques, and reporting methods. (long term)
15. Fund a national prospective survey of minority pregnant women to test hypotheses about low birthweight and other adverse pregnancy outcomes. (long term)
16. Coordinate dissemination of information concerning infant mortality and application of research findings to prevention of infant and maternal morbidity and mortality. (medium term)
17. Identify and study special subgroups of minorities to provide new insights into racial and ethnic differences in low birthweight. (long term)



# Substance Abuse

## SUBSTANCE ABUSE: Strategic Goals and Objectives

### Goal I: Outreach

To characterize, prevent, treat, and control drug and alcohol use in minority communities, including difficult-to-reach populations at high risk. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Encourage healthful attitudes among minority youth concerning the link between substance abuse and life problems such as school failure, unwanted pregnancy, delinquency, and medical and psychological problems. (short term)
2. Give high priority to prevention and treatment for addictive substances that affect minority youth. (short term)
3. Greatly increase drug and alcohol abuse outreach and family support programs through funding community-based organizations. (medium term)
4. Develop minority specific programs of drug and alcohol abuse risk factor reduction. (long term)
5. Promote school and community youth programs of drug and alcohol education and screening for drug and alcohol problems. (short term)
6. Use multicultural mass media campaigns to warn minorities of the dangers of experimenting with drugs and alcohol. (short term)
7. Develop programs to encourage positive relationships between youth and adult family members. (medium term)
8. Develop outreach and prevention programs to discourage the use of alcohol, tobacco products, and marijuana among preteen minority youth. (immediate)
9. Clarify the correlation between drug and alcohol use and suicides, homicides, drownings, automobile and boating accidents and injuries, liability, and criminal prosecution. (short term)
10. Assist minority youth in developing positive behaviors, building coping skills, and strengthening bonds to family members. (short term)

## SUBSTANCE ABUSE

### Goal II: Patient Education

Encourage a drug-free lifestyle among minority groups by providing culturally appropriate information about the dangers of drug and alcohol use and the availability of effective treatment. (Secretary's Task Force Recommendation 2)

### **Objectives**

1. Assist public schools with large minority enrollments to include culturally relevant health education on drug and alcohol use, not merely in health education classes, but also in classes such as biology, social studies, and history. One form of assistance might be to develop a national core curriculum in drug-related studies. (short term)
2. Develop education programs, patient counseling, and pregnancy planning programs for minority men and women concerning the dangers of drug and alcohol use during pregnancy. (short term)
3. Use all available media to educate minorities concerning the availability of drug and alcohol hotlines and referral services. Publicize those that can provide multicultural assistance. (short term)
4. Develop, promote, and disseminate culturally appropriate drug and alcohol diagnostic and referral criteria for primary and other health care professionals. (long term)
5. Develop culturally sensitive health education messages that explain, in a personally relevant way, the consequences of drug and alcohol use. Provide healthful role models to encourage healthful behavior. (medium term)
6. Disseminate more drug and alcohol use information to the full range of target groups within the minority community. Emphasize the important role of the whole family in deterring and treating substance abuse. (short term)
7. Encourage patient education to stress disease concepts and abstinence-based models of recovery. (immediate)

## **SUBSTANCE ABUSE**

### **Goal III: Delivery and Financing of Health Services**

Provide the full spectrum of health care services necessary to prevent and treat inappropriate drug and alcohol abuse in minority communities. (Secretary's Task Force Recommendation 3)

### **Objectives**

1. Improve and expand programs of drug and alcohol treatment in all levels of correctional institutions. (medium term)
2. Expand drug and alcohol treatment services and facilities. (short term)
3. Require all third-party payment plans, including Medicaid and Medicare, to offer coverage for comprehensive drug and alcohol treatment. Require that insurance costs for such services be based on actuarial data from the population at large, not from an individual minority community or section of a city. (medium term)
4. Give high priority to developing diagnostic criteria that will help indicate what form of intervention and treatment program is most likely to be successful for a given minority person. Involve minorities in developing the criteria. (medium term)
5. Develop a multiplicity of intervention and treatment programs that are culturally relevant to the minority community. In addition to standard care, such programs might include:



- ☐ detoxification
  - ☐ crisis intervention
  - ☐ alternative activity programs
  - ☐ school-based interventions
  - ☐ posttreatment services
  - ☐ spiritual programs
  - ☐ daycare
  - ☐ drop-in centers
  - ☐ aftercare (long term)
6. Affirmatively involve minority organizations and individuals in the planning and operations of all programs of community-based prevention, risk factor reduction, and drug and alcohol abuse intervention and treatment. (short term)
  7. Expand the number of drug and alcohol treatment slots within minority communities, to a total that is equal to the number of persons seeking treatment. Create alternative treatment modalities as appropriate to minority patients' needs. The number of slots developed should be based on present need rather than on projections from historical data. (medium term)
  8. Continue and expand Federal financial assistance to State and local programs of drug and alcohol prevention and treatment. Earmark an appropriate proportion of funds to be used solely for minority community programs, particularly programs for youth and families. (medium term)

## **SUBSTANCE ABUSE**

### **Goal IV: Non-Federal Health Professions Education**

Ensure that an appropriate number and mix of health professionals in drug and alcohol treatment are available and accessible to minority communities. (Secretary's Task Force Recommendation 4)

#### ***Objectives***

1. Improve systems for the recruitment, training, placement, and retention of drug and alcohol treatment personnel within minority communities. Make greater use of personnel indigenous to the community. (short term)
2. Educate medical students and primary care physicians about the early signs of alcohol and drug abuse, and teach them how to screen and treat patients in early stages. (medium term)
3. Provide financial incentives and enhanced working environments to promote retention of drug and alcohol treatment professionals working in community-based programs. (medium term)

## **SUBSTANCE ABUSE**

### **Goal V: Federal Health Professions Education**

Provide appropriate training to increase the number of drug and alcohol treatment professionals available and accessible to minority communities. Expand the skills of existing health care personnel and other professionals who can influence drug or alcohol behavior. (Secretary's Task Force Recommendation 5)

#### ***Objectives***

1. Train school personnel in the skills needed to recognize students at high risk for drug or alcohol use. Coordinate school health efforts with community-based prevention and intervention programs within the minority community. Such training should be appropriate to the responsibilities of different groups of personnel. (short term)
2. Continue and update minority drug and alcohol health professional training programs, incorporating new information concerning the role of individual, family, behavioral, and social effects of addiction. (medium term)
3. Develop drug and alcohol abuse diagnostic criteria and treatment protocols appropriate to minority community needs. Widely disseminate such standards. (medium term)

## **SUBSTANCE ABUSE**

### **Goal VI: Building the Capacity of Non-Federal Health Resources**

Increase the number of drug and alcohol prevention and treatment resources at the grassroots community level and provide a continuum of health care appropriate to minorities. (Secretary's Task Force Recommendation 6)

#### ***Objectives***

1. Develop approaches to minority rehabilitation that are appropriate to new drugs and patterns of addiction such as crack, ice, and other emerging problems. (short term)
2. Encourage greater integration of drug treatment with the primary health care systems in minority communities. (medium term)
3. Develop effective working relationships among the courts, schools, and minority community-based drug and alcohol abuse intervention programs. (medium term)
4. Expand the number of community-based drug and alcohol prevention, treatment, and intervention programs, developing approaches appropriate to specific minority communities. (medium term)
5. Develop, continue, and expand employee assistance and drug and alcohol counseling programs. Target industries with a high proportion of minority workers. Provide incentives for participation. (short term)
6. Continue and expand drug-free workplace programs. (medium term)
7. Support strict enforcement of driving laws concerning alcohol and drug use, while consistently providing appropriate treatment and education programs. (short term)

## **SUBSTANCE ABUSE**

### **Goal VII: Data**

Develop databases to better understand the newly evolving patterns of drug and alcohol use and their effects on minority communities. (Secretary's Task Force Recommendation 7)

#### ***Objectives***

1. Develop new epidemiologic surveillance, data collection, analysis, and reporting techniques to monitor and better understand the emerging drug epidemic. Involve minority representatives in planning research, determining sampling methods, and participating in investigations. (short term)
2. Monitor new patterns in drug and alcohol use and dependency, particularly the factors influencing minority youth. (short term)
3. Develop mechanisms to refer persons with alcohol and other drug-related emergency room visits to alcohol and drug treatment programs that involve the entire family. (short term)
4. Collect and analyze data concerning minority families in which substance abuse occurs or in which family members are at high risk. Also collect data on families in which alcohol and drug use is not a problem. The purpose would be to identify the factors that deter drug and alcohol use and to determine the most effective family interventions where substance abuse already occurs. (long term)
5. Fund minority principal investigators to develop minority data capture and analysis strategies. (medium term)

## **SUBSTANCE ABUSE**

### **Goal VIII: Research**

Increase knowledge of the changing minority drug and alcohol problem as it relates to etiology, environmental factors, psychological risk factors, risk reduction, prevention, diagnosis, treatment, and control. Continue and expand ethnographic and biomedical research, and describe the natural history of the full range of habituating substances as new patterns of use emerge in minority communities. (Secretary's Task Force Recommendation 8)

#### ***Objectives***

1. Evaluate current methods to identify minority persons who are at high risk for drug or alcohol abuse. In particular, evaluate and improve methods to identify high-risk youths, high-risk families, high-risk adults, and high-risk women of childbearing age. (medium term)
2. Conduct further research on the connection between substance abuse and homicide, suicide, family violence, and child neglect. (immediate)





# Access and Financing

## ACCESS AND FINANCING: Strategic Goals and Objectives

### Goal I: Outreach

Develop an outreach program to educate minority populations about the availability of Federal, State, private, and other mechanisms to finance health care services. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Develop a national policy for Medicaid administrators that specifies more expeditious procedures to process Medicaid eligibility, including fast-track mechanisms for any patient presenting with urgent health care needs. (short term)
2. Develop minimum acceptable state guidelines for interstate Medicaid eligibility. These guidelines would apply to all Americans but would particularly benefit transient minority groups such as migrant workers, persons who change residences frequently, and the homeless. (short term)
3. Include preventive health care benefits in all health care financing approaches. (long term)

## ACCESS AND FINANCING

### Goal II: Patient Education

Educate minority populations about health care services, alternative providers, third-party payors available to them, and the processes used to obtain coverage and make claims for reimbursement or secure delivery of service. (Secretary's Task Force Recommendation 2)

#### *Objectives*

1. Develop more culturally sensitive triage and intake procedures for health care facilities. Target culturally sensitive assistance to minorities and minority subgroups throughout the course of diagnosis, treatment, and followup. (long term)
2. Develop systems of case management to ensure that each patient understands the procedures for accessing health care. Develop communications approaches that meet minority needs across the spectrum of subpopulations. (long term)
3. Develop a model case management procedures manual to address individual subgroup minority needs. Encourage applications of the procedures, especially in diseases that disproportionately affect minorities. (medium term)

## **ACCESS AND FINANCING**

### **Goal III: Delivery and Financing**

Identify financial factors that affect the availability of health care for minority populations. Ensure the highest quality of services to minorities and monitor services delivery against guidelines and consensus standards. (Secretary's Task Force Recommendation 3)

#### **Objectives**

1. Examine the mainstream of health care funding as it affects minorities, particularly group and individual insurance, and employer health care financing mechanisms. (medium term)
2. Examine how the policies of Federal, State, and local funding affect the availability of health care in minority communities. (medium term)
3. Develop financial triage methods to redirect both private and public health care funds away from acute care toward a balanced approach of primary prevention, secondary prevention, community medicine, and specialized ambulatory and acute care. (medium term)
4. Determine the impact of Medicare, Medicaid, and private financing policies on health care services available to minority communities. (medium term)
5. Determine the effects of rationalized health care delivery policies on the health status of minorities. (long term)
6. Identify the cost and other financial issues that affect hospitals and other health care providers serving minority communities. (medium term)
7. Develop a national plan for overcoming the financial barriers to access for minority groups. (short term)
8. Monitor employment policies regarding health care benefits and barriers as they affect minority populations. (short term)
9. Develop a strategy for extending health care coverage for uninsured and underinsured communities through mechanisms such as statewide risk pools. (long term)
10. Monitor and evaluate the extent and effects of cost-containment strategies such as managed care, utilizations review, and health care rationing on the availability of health care services for minority populations. (medium term)
11. Assess and determine the primary care, preventive, and educational services that could have the largest effect on reducing the overall cost of health care for minorities. (short term)
12. Develop minimum standards for health care services provided to minority populations. Find ways to promote rationalized community-based systems to provide prevention, primary care, and specialized ambulatory outpatient care within minority communities. (medium term)
13. Incorporate availability, accessibility, and quality of care standards in all program evaluation and needs assessments. (medium term)
14. Require minimum quality of care standards to be applied in all funded demonstration projects. (medium term)

15. Assist communities in targeting resources and restructuring systems for providing care. (short term)

## **ACCESS AND FINANCING**

### **Goal IV: Non-Federal Health Professions Education**

Develop a strategy for increasing the supply of minority physicians and other health care providers trained in minority health issues. Encourage and provide incentives for providers to locate in minority communities. (Secretary's Task Force Recommendation 4)

(Specific recommendations were not developed for this area. Applicable strategic objectives were developed by the Health Issues Working Group on Health Professions.)

## **ACCESS AND FINANCING**

### **Goal V: Federal Health Professions Education**

Disseminate widely the best and most current health care practice information through clearinghouses and other means. (Secretary's Task Force Recommendation 5)

(Specific recommendations were not developed for this area. Applicable strategic objectives were developed by the Health Issues Working Group on Health Professions.)

## **ACCESS AND FINANCING**

### **Goal VI: Building the Capacity of Non-Federal Health Resources**

Develop, expand, and finance alternative delivery systems of comprehensive, continuous care such as managed care, health maintenance organizations, and preferred provider organizations. Encourage minority public and private partnerships (Secretary's Task Force Recommendation 6).

#### ***Objectives***

1. Identify, at State and community levels, functioning models of alternative delivery systems providing a continuum of health care for minorities. (short term)
2. Commit sufficient resources for health services research in alternative delivery sites across the Nation, developing self-sustaining cooperative models. (medium term)
3. Develop and implement a national plan for the replication of effective and efficient alternative minority health care delivery system models. (long term)

## **ACCESS AND FINANCING**

### **Goal VII: Data**

Establish through the National Health Interview Survey (NHIS) adequate data surveillance systems to monitor mortality and morbidity rates by condition, the adequacy of third-party payor coverage, and access, availability, and utilization of



services for minority populations. Standardize minority health service data collection and link data systems using the social security number as an identifier. (Secretary's Task Force Recommendation 7)

**Objectives**

1. Increase the sample size of minorities in the 1995 NHIS and other minority health information gathering activities. (medium term)
2. In cooperation with the minority community, determine data elements needed and evaluate the NHIS questionnaire. Consider addition of items on access, financing, and coverage for care. (medium term)
3. Periodically evaluate the NHIS questionnaire for its suitability to identify the effects of reimbursement policy changes on the levels of utilization of services by minority populations. (long term)
4. Increase the frequency of collection of minority health insurance and other private financing data on the current health topics portion of the NHIS. (short term)
5. Develop strategic and operational plans for the collection of minority health data, utilization data, financial data, and health outcome data. (long term)

**ACCESS AND FINANCING**

**Goal VIII: Research**

Assess health care delivery needs related to issues such as availability, adequacy, and diversity of insurance coverage, other financing mechanisms, cultural acceptability, financial barriers, and geographic access. Deliver appropriate technical assistance to minority communities. (Secretary's Task Force Recommendation 8)

**Objectives**

1. Conduct a technical analysis of means to develop a minority, process-based database for assessing health care and research policies. (medium term)
2. Identify the data elements needed to measure and monitor progress in implementing the objectives of the OMH strategic planning process for minority health. (short term)
3. Examine the service utilization patterns of uninsured and underinsured minority populations. (medium term)
4. Conduct targeted studies of minority populations covered by the NHIS using re-interview techniques to obtain more detailed information on access and financing of care. (short term)
5. Examine and test the effect of different service settings such as community health centers, school-based programs, and other alternative settings on minority access to care. (medium term)
6. Assess alternative minority delivery system models from the following perspectives: increased flexibility of health care delivery, facility of access, efficiency and cost effectiveness of service delivery and payment systems, costs, adequacy of resources, cultural acceptability, effectiveness of linkages within the continuum of services, clinical effectiveness, and



- impact of the program/system on the health status of the population served. (medium term)
7. Expand demonstrations of various newly emerging models of effective alternative systems of health care in minority underserved areas. (medium term)
  8. Fund projects to identify newly emerging factors contributing to program effectiveness. Determine program transportability to other underserved communities. (medium term)



# Data

## DATA: Strategic Goals and Objectives

**Goal: Ensure that there are valid available and reliable health data on each major racial/ethnic group in the United States. (Secretary's Task Force Recommendation 7)**

Data Collection

### Objectives

1. Collect information on data systems within DHHS to determine what is collected. (short term)
2. Review existing data systems within DHHS to determine if appropriate data are being collected to identify specific racial/ethnic groups. Ethnic groups should be broken down into the following groups: White (not Hispanic), Black (not Hispanic), Hispanic, Native American, and Asian/Pacific Islander. Focus on the smallest subgroup possible that will still yield reliable statistics (e.g., Hispanics can be broken down into Mexican Americans, Mainland Puerto Ricans, Cuban Americans, and other Hispanics). (short term)
3. Conduct pilot studies to determine if there are significant differences between subgroups. Subgroups should reflect changes in the population. (For example, because of the increasing population of Mainland Puerto Ricans, they should be considered a subgroup of Hispanics). (short term)
4. Each study design must incorporate measures that demonstrate that the objectives will have a positive impact on ethnic minorities. This includes appropriate data collection methods and an adequate sample size for making reliable statistical estimates for the specific racial/ethnic group. Record source of race/ethnicity information. (short term)
5. Where appropriate, develop mechanisms for linking individual records from different data sets within DHHS for statistical research purposes. (medium term)
6. Augment existing surveillance systems to ensure adequate coverage of each racial/ethnic group so that new and emerging health problems and potential risk factors can be identified and existing health problems monitored. (medium term)
7. Develop, through appropriate DHHS agencies, appropriate qualitative and quantitative data collection systems for small-area data analysis by nongovernmental agencies. This involves collecting data at the county level and, when appropriate, aggregating county data to yield reliable regional and national estimates. (medium term)
8. Encourage the Census Bureau to collect more information on race and ethnicity and to provide intercensal estimates. (short term)

9. Ensure that in all surveys, epidemiological studies, evaluations, and other research studies the necessary criteria, critical data for analysis, variables, randomization procedures, end points of the survey or study, and stopping rules are considered in the planning stage and are included in the protocol. (medium term and continuing)
10. Encourage expansion and design of major National Center for Health Statistics (NCHS) surveys to include and/or allow sufficiently large samples to provide reasonably accurate estimates for individual states. (short term and continuing)
11. Maintain up-to-date records and disseminate information of study changes and modifications. Develop guidelines where needed and monitor compliance. (short term)
12. Work with states to encourage more complete reporting and to improve the accuracy of diagnoses for all racial/ethnic groups. (short term)
13. Work with states to reduce the potential for inconsistent reporting of diseases among the specific racial/ethnic groups. (long term)

## **DATA**

### **Data Analysis**

#### **Objectives**

1. Conduct and publish more detailed race/ethnicity-specific analyses of existing data sets. (short term)
2. Conduct race/ethnicity-specific time-trend analyses of health and health services. The results will serve as the basis for interventions and for monitoring the impact of such interventions. (short term)
3. Conduct specific analyses to identify gaps in data needs. (short term)
4. Encourage the use of modeling (e.g., multivariate analysis, cost/benefit analysis, and state-of-the-art statistical techniques), as well as more traditional analyses. (short term)
5. Conduct cost/benefit analyses to determine if the additional benefits, in terms of technical accuracy and scientific validity of oversampling minorities in national surveys, are greater than the additional budgetary costs. (short term)

## **DATA**

### **Data Translation and Dissemination**

#### **Objectives**

1. Require all DHHS agencies that collect health data from individuals to include race and ethnic identifiers and to record source of ethnic determination (e.g., birth certificate, self-reporting). Race and ethnic identifiers must be standardized within DHHS. (short term)
2. Encourage and assist non-DHHS government agencies (Federal, State, and local) to adopt the standardized race and ethnic identifiers used within DHHS. This includes encouraging the States to modify birth, death,



- marriage, and divorce certificates to include standardized race and ethnic identifiers. (short term)
3. Encourage and assist health care institutions to adopt the standardized race and ethnic identifiers used within DHHS. (short term)
  4. Encourage and assist States to train personnel to accurately complete vital statistics records. This includes accurate coding of causes of death on death certificates and accurate coding of race and ethnicity on all certificates. (short term)
  5. Encourage and assist States to include geocode identifiers on routinely collected data for small-area data analysis below the county level and to develop the system for these routine analyses (e.g., analysis by ZIP Code, census tracts). (short term)
  6. Encourage and assist States to substantiate priority health problem areas according to objective, epidemiologic-based criteria. (short term)
  7. Establish a mechanism to evaluate the quality of information on death certificates to determine if States are following the guidelines for completing the certificates. (medium term)
  8. Strengthen and expand efforts with the States to develop a national database of linked birth and death records. (short term and continuing)
  9. Help population-based disease registries improve the quality of their data by adopting DHHS-standardized data collection methods. (short term)
  10. Develop and encourage the use of a data collection model for application at the local level, which communities can use to identify their own needs and develop appropriate interventions at the local level. (short term and continuing)
  - 11. Collaborate with non-Federal agencies to develop a database on health beliefs and practices, health needs, and sources of health information. (short term and continuing)
  12. Improve the timeliness of data reported by NCHS so that data collected in a given year are available by the end of the following year. The goal is timely interventions. (short term)
  13. Disseminate information via professional meetings, published reports in appropriate journals, and presentations to appropriate groups, including community-based organizations, individuals, and policymakers. (short term)



# Health Professions

## HEALTH PROFESSIONS: Strategic Goals and Objectives

### Goal I: Outreach

Promote health professions education in minority communities, especially targeting pre-secondary school youth. (Secretary's Task Force Recommendation 1)

#### *Objectives*

1. Develop community-based programs to increase minority awareness of available health professions training and education resources. (immediate)
2. Deploy and retain an adequate supply of minority health professionals in minority communities. (long term)
3. Provide incentives to retain minority health professionals in their communities. (medium term)
4. Improve awareness and accountability of Federal health professions education programs. (short term)
5. Increase minority knowledge of the need for appropriate health care in culturally relevant settings. (immediate)
6. Use innovative communications to promote health professions career choices among minorities at all levels of the educational system. (immediate)
7. Develop leadership conferences and incentives to interest young minority persons in health professions careers. (immediate)
8. Strengthen educational cooperation among State Departments of Health, non-Federal resources, and the Federal Government in recruiting and retaining minority health professionals. (medium term)
9. Implement minority programs of early awareness about the choices and challenges of health care professions careers. (short term)
10. Encourage young minority students and help give them the self-confidence to choose health professions careers. (short term)

## HEALTH PROFESSIONS

### Goal II: Patient Education

Ensure that all health care providers are trained in multicultural patient communications and in the management of medical conditions prevalent among minorities. (Secretary's Task Force Recommendation 2)

#### *Objectives*

1. Develop professional education curricula for health professionals of all communities that emphasize multicultural communications. (short term)

2. Provide multicultural training in the medical, social, and communications aspects of minority patient care to health care providers who serve minority patients. (medium term)
3. Use innovative patient communications strategies such as video, interactive software, and teleconferencing within minority communities. (medium term)

## **HEALTH PROFESSIONS**

### **Goal III: Delivery and Financing**

Provide assistance and incentives to increase the number of minority health professionals being trained in private, public, and governmental sectors. (Secretary's Task Force Recommendation 3)

#### ***Objectives***

1. Change legislative language to increase minority participation in all health programs across the full range of agencies. (long term)
2. Establish priorities or funding preferences as incentives for minority participation. (short term)
3. Earmark a portion of Federal health agency budgets specifically for minority populations. (short term)
4. Collaborate with the private sector to mount a minority-oriented educational effort. (short term)
5. Establish a minority health component of Federal agency programs and promote participation and cooperation of other institutions. (short term)
6. Earmark a portion of minority-specific program funds to be used as incentives to prompt general programs to develop or improve a minority component of their programs. (medium term)

## **HEALTH PROFESSIONS**

### **Goal IV: Non-Federal Health Professions Education**

Increase the involvement of state and local government and private and public organizations in expanding resources for minority health professions education. (Secretary's Task Force Recommendation 4)

#### ***Objectives***

1. Form demonstration project partnerships between Federal agencies, state governments, educational institutions, and organizations that represent state higher education systems. (medium term)
2. Collaborate with the appropriate State Education Commission and the health care industry to improve minority access to higher education in biotechnology and technology development careers. (medium term)
3. Collaborate with the appropriate State economic development organizations to include minorities in economic development strategies related to health sciences and biotechnology services. (medium term)
4. Encourage health industry employers to develop health science and services organizations located in minority communities and areas of economic need. (medium term)



## **HEALTH PROFESSIONS**

### **Goal V: Federal Health Professions Education**

Increase the number of minority health professionals educated and trained in federally supported programs. Apply innovative techniques to recruit and retain minority health professions students. (Secretary's Task Force Recommendation 5)

#### ***Objectives***

1. Encourage and assist the Office of Management and Budget's effort to add a minority emphasis to existing or planned programs. (short term)
2. Establish specific targets for the number of programs with an OMB-stimulated minority emphasis. (short term)
3. Monitor progress, adjust targets and timeframes, and provide technical assistance where needed. (short term)
4. Begin immediately to expand HCOP and target some of its resources to selected disciplines, particularly health promotion and prevention. (medium term)
5. Cooperate with education departments to develop curriculum; allow HCOP to be flexible in choosing innovative disciplines. (medium term)
6. Improve coordination among Centers for Disease Control, Health Resources and Services Administration, and National Institute of Mental Health research and clinical training activities and OMH's community-based risk reduction coalition activities. (medium term)
7. Improve coordination among clinical training programs such as HCOP and Area Health Education Centers and Federal service delivery programs such as community health centers, migrant health centers, and community mental health centers. (short term)
8. Explore ways to link Federal health professions development activities with federally funded health care delivery and prevention activities at all levels. (short term)

## **HEALTH PROFESSIONS**

### **Goal VI: Building Non-Federal Resources**

Stimulate the development of new non-Federal organizations to participate in education and training programs for minority health professionals. (Secretary's Task Force Recommendation 6)

#### ***Objectives***

1. Formulate and implement strategies for Federal, state, and private sector (businesses, foundations) partnership activities. (short term)
2. Form an expert panel to build partnerships and collaborations among non-Federal organizations. (immediate)
3. Stimulate business and civic organizations to develop programs to effectively supplement basic education and enhance the academic preparation of minority students. (medium term)
4. Collaborate with the health care industry to demonstrate the commercial benefits of training minority health professionals to promote health professional education for minorities. The insurance, health industry

manufacturers, proprietary care facilities, emergency medical services, and pharmaceutical companies are several possibilities. (medium term)

## **HEALTH PROFESSIONS**

### **Goal VII: Data**

Collect and analyze data on minorities in health professions education. Determine numbers and specialties of minority professionals trained and the location in which minority professionals have chosen to practice. (Secretary's Task Force Recommendation 7)

#### **Objectives**

1. Encourage Federal and other health professions education programs to document the number of minority students applying, enrolled, and graduated. Such data should be categorized by professional specialty and by specifically defined minority subgroups. (short term)
2. Require that Federal programs of minority health professions education follow participants for at least a 10-year period to determine where they choose to practice. (long term)

## **HEALTH PROFESSIONS**

### **Goal VIII: Research**

Identify and adapt research and demonstration programs to determine the best ways to recruit, educate, and facilitate graduation of minority health professionals. (Secretary's Task Force Recommendation 8)

#### **Objectives**

1. Emphasize incentives to attract minority health professionals to practice in their respective communities. (medium term)
2. Stimulate and support the development of research and demonstration programs to determine how best to recruit minority youth for health professions education and training. (medium term)
3. Identify effective incentives to retain minority health professionals in their communities. (long term)
4. Study the cultural, financial, professional, and other disincentives that discourage both minority and nonminority health professionals from locating in minority communities. (short term)
5. Evaluate and improve the impact of current Federal efforts. (short term)
6. Determine the most formative point in the evolution of a minority student's career in the health professions. Develop specific interventions to encourage his or her choice of health careers. (medium term)
7. Use advertising and media techniques to interest minority persons in health professions. Assist them with educational financing. (medium term)
8. Collect creditable information concerning the success of different programs, comparing traditional versus novel minority-focused health professions training and education. (medium term)



## APPENDIX A

# Special Population Objectives

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Excerpted from

*Healthy People 2000:  
National Health  
Promotion and  
Disease Prevention  
Objectives*

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## Contents

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# Special Population Objectives

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Duplicate objectives, which appear in two or more priority areas, are marked with an asterisk (\*).

Except as otherwise noted, all rates in the following objectives are annual. Where the baseline rate is age adjusted, it is age adjusted to the 1940 U.S. population, and the target is age adjusted also.

## Objectives Targeting Blacks

- 2.3b\* Reduce overweight to a prevalence of no more than 30 percent among black women aged 20 and older. (Baseline: 44 percent for black women aged 20 through 74 in 1976-80)

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

- 2.4a Reduce growth retardation among low-income black children younger than age 1 to less than 10 percent. (Baseline: 15 percent in 1988)

*Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*

- 2.10e Reduce the prevalence of anemia to less than 20 percent among black, low-income pregnant women. (Baseline: 41 percent of those aged 15 through 44 in their third trimester in 1988)

*Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.*

- 3.4d\* Reduce cigarette smoking to a prevalence of no more than 18 percent among blacks aged 20 and older. (Baseline: 34 percent in 1987)

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

- 4.2a Reduce cirrhosis deaths among black men to no more than 12 per 100,000 black men. (Age-adjusted baseline: 22 per 100,000 in 1987)

- 5.1a Reduce pregnancies among black adolescent girls aged 15 through 19 to no more than 120 per 1,000 black adolescents. (Baseline: 186 per 1,000 for non-white adolescents in 1985)

*Note: For black and Hispanic adolescent girls, baseline data are unavailable for those aged 15 through 17. The targets for these two populations are based on data for women aged 15 through 19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.*

- 5.2a Reduce to no more than 40 percent the proportion of all pregnancies among black women that are unintended. (Baseline: 78 percent of pregnancies in the previous 5 years were unintended, either unwanted or earlier than desired, in 1988)

- 5.3a Reduce the prevalence of infertility among black couples to no more than 9 percent. (Baseline: 12.1 percent of married couples with wives aged 15 through 44 in 1988)

*Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.*

- 7.1c Reduce homicides among black men aged 15 through 34 to no more than 72.4 per 100,000 black men. (Baseline: 90.5 per 100,000 in 1987)

- 7.1e Reduce homicides among black women aged 15 through 34 to no more than 16.0 per 100,000 black women. (Baseline: 20.0 per 100,000 in 1987)

- 8.1a\* Increase years of healthy life among blacks to at least 60 years. (Baseline: An estimated 56 years in 1980)

*Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.*



- 8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)
- Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.*
- 9.1b Reduce deaths among black males caused by unintentional injuries to no more than 51.9 per 100,000 black males. (Age-adjusted baseline: 64.9 per 100,000 in 1987)
- 9.4c Reduce deaths among black men aged 30 through 69 from falls and fall-related injuries to no more than 5.6 per 100,000 black men. (Baseline: 8 per 100,000 in 1987)
- 9.5c Reduce drowning deaths among black males to no more than 3.6 per 100,000 black males. (Age-adjusted baseline: 6.6 per 100,000 in 1987)
- 9.6c Reduce residential fire deaths among black males to no more than 4.3 per 100,000 black males. (Age-adjusted baseline: 5.7 per 100,000 in 1987)
- 9.6d Reduce residential fire deaths among black females to no more than 2.6 per 100,000 black females. (Age-adjusted baseline: 3.4 per 100,000 in 1987)
- 11.1a Reduce asthma morbidity among blacks, as measured by a reduction in asthma hospitalizations to no more than 265 per 100,000 blacks. (Baseline: 334 per 100,000 blacks and other non-whites in 1987)
- 11.4a Reduce the prevalence of blood lead levels exceeding 15 µg/dL and 25 µg/dL among inner-city low-income black children (annual family income less than \$6,000 in 1984 dollars) to no more than 75,000 and zero, respectively. (Baseline: An estimated 234,900 had levels exceeding 15 µg/dL, and 36,700 had levels exceeding 25 µg/dL, in 1984)
- 13.1c Reduce dental caries (cavities) so that the proportion of black children aged 6 through 8 with one or more caries (in permanent or primary teeth) is no more than 40 percent. (Baseline: 61 percent in 1986-87)
- 13.2c Reduce untreated dental caries so that the proportion of black children with untreated caries (in permanent or primary teeth) is no more than 25 percent among children aged 6 through 8 and no more than 20 percent among adolescents aged 15. (Baseline: 38 percent of black children aged 6 through 8 in 1986-87; 38 percent of black adolescents aged 15 in 1986-87)
- 14.1a Reduce the infant mortality rate among blacks to no more than 11 per 1,000 live births. (Baseline: 17.9 per 1,000 live births in 1987)
- 14.1e Reduce the neonatal mortality rate among blacks to no more than 7 per 1,000 live births. (Baseline: 11.7 per 1,000 live births in 1987)
- 14.1h Reduce the postneonatal mortality rate among blacks to no more than 4 per 1,000 live births. (Baseline: 6.1 per 1,000 live births in 1987)
- Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.*
- 14.2a Reduce the fetal death rate (20 or more weeks of gestation) among blacks to no more than 7.5 per 1,000 live births plus fetal deaths. (Baseline: 12.8 per 1,000 live births plus fetal deaths in 1987)
- 14.3a Reduce the maternal mortality rate among blacks to no more than 5 per 100,000 live births. (Baseline: 14.2 per 100,000 live births in 1987)
- Note: The objective uses the maternal mortality rate as defined by the National Center for Health Statistics. However, if other sources of maternal mortality data are used, a 50-percent reduction in maternal mortality is the intended target.*
- 14.4b Reduce the incidence of fetal alcohol syndrome among blacks to no more than 0.4 per 1,000 live births. (Baseline: 0.8 per 1,000 live births in 1987)
- 14.5a Reduce low birth weight among blacks to an incidence of no more than 9 percent of live births and very low birth weight to no more than 2 percent of live births. (Baseline: 12.7 and 2.7 percent, respectively, in 1987)
- Note: Low birth weight is weight at birth of less than 2,500 grams; very low birth weight is weight at birth of less than 1,500 grams.*

- 14.9b\* Increase to at least 75 percent the proportion of black mothers who breastfeed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 25 percent at discharge from birth site and 8 percent at 5 to 6 months in 1988)
- 14.11a Increase to at least 90 percent the proportion of pregnant black women who receive prenatal care in the first trimester of pregnancy. (Baseline: 61.1 percent of live births in 1987)
- 15.1a\* Reduce coronary heart disease deaths among blacks to no more than 115 per 100,000 blacks. (Age-adjusted baseline: 163 per 100,000 in 1987)
- 15.2a Reduce stroke deaths among blacks to no more than 27 per 100,000 blacks. (Age-adjusted baseline: 51.2 per 100,000 in 1987)
- 15.3a Reverse the increase in end-stage renal disease (requiring maintenance dialysis or transplantation) among blacks to attain an incidence of no more than 30 per 100,000 blacks. (Baseline: 32.4 per 100,000 in 1987)
- 15.5b Increase to at least 80 percent the proportion of black hypertensive men aged 18 through 34 who are taking action to help control their blood pressure. (Baseline: 63 percent of aware black hypertensive men aged 18 through 34 were taking action to control their blood pressure in 1985)
- Note: High blood pressure is defined as blood pressure equal to or greater than 140 mm Hg systolic and/or 90 mm Hg diastolic and/or taking antihypertensive medication. Actions to control blood pressure include taking medication, dieting to lose weight, cutting down on salt, and exercising.*
- 16.11e Increase to at least 80 percent the proportion of black women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years. (Baseline: 28 percent of black women aged 40 and older "ever" in 1987; 19 percent of black women aged 50 and older "within the preceding 2 years" in 1987)
- 17.2c Reduce to no more than 9 percent the proportion of blacks who experience a limitation in major activity due to chronic conditions. (Baseline: 11.2 percent in 1988)
- Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.*
- 17.9a Reduce diabetes-related deaths among blacks to no more than 58 per 100,000 blacks. (Age-adjusted baseline: 65 per 100,000 in 1986)
- 17.10a Reduce end-stage renal disease due to diabetes among blacks with diabetes to no more than 2 per 1,000 blacks with diabetes. (Baseline: 2.2 per 1,000 in 1983-86)
- 17.10c Reduce lower extremity amputations due to diabetes among blacks with diabetes to no more than 6.1 per 1,000 blacks with diabetes. (Baseline: 10.2 per 1,000 in 1984-87)
- Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.*
- 17.11e Reduce diabetes among blacks to a prevalence of no more than 32 per 1,000 blacks. (Baseline: 36 per 1,000 in 1987)
- 18.1b Confine annual incidence of diagnosed AIDS cases among blacks to no more than 37,000 cases. (Baseline: An estimated 14,000-15,000 cases diagnosed in 1989)
- Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.*
- 19.1a Reduce gonorrhea among blacks to an incidence of no more than 1,300 cases per 100,000 blacks. (Baseline: 1,990 per 100,000 in 1989)
- 19.3a Reduce primary and secondary syphilis among blacks to an incidence of no more 65 cases per 100,000 blacks. (Baseline: 118 per 100,000 in 1989)
- 20.4b Reduce tuberculosis among blacks to an incidence of no more than 10 cases per 100,000 blacks. (Baseline: 28.3 per 100,000 in 1988)
- 21.2h Increase to at least 50 percent the proportion of blacks who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)



- 21.3b Increase to at least 95 percent the proportion of blacks who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: Less than 80 percent in 1986, as 20 percent reported having no physician, clinic, or hospital as a regular source of care)
- 21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

	1985-1986 Baseline	2000 Target
Blacks	5%	8%

*Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.*

- 22.4 Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

*Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.*

## Objectives Targeting Hispanics

- 2.3c\* Reduce overweight to a prevalence of no more than 25 percent among Hispanic women aged 20 and older. (Baseline: 39 percent for Mexican-American women aged 20 through 74, 34 percent for Cuban women aged 20 through 74, and 37 percent for Puerto Rican women aged 20 through 74 in 1982-84)

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

- 2.4b Reduce growth retardation among low-income Hispanic children younger than age 1 to less than 10 percent. (Baseline: 13 percent in 1988)

*Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*

- 2.4c Reduce growth retardation among low-income Hispanic children aged 1 to less than 10 percent. (Baseline: 16 percent in 1988)

*Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*

- 3.4e\* Reduce cigarette smoking to a prevalence of no more than 18 percent among Hispanics aged 20 and older. (Baseline: 33 percent in 1982-84)

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

- 5.1b Reduce pregnancies among Hispanic adolescent girls aged 15 through 19 to no more than 105 per 1,000 Hispanic adolescents. (Baseline: 158 per 1,000 in 1985)

*Note: For black and Hispanic adolescent girls, baseline data are unavailable for those aged 15 through 17. The targets for these two populations are based on data for women aged 15 through 19. If more complete data become available, a 35-percent reduction from baseline figures should be used as the target.*

- 5.3b Reduce the prevalence of infertility among Hispanic couples to no more than 9 percent. (Baseline: 12.4 percent of married couples with wives aged 15 through 44 in 1988)

*Note: Infertility is the failure of couples to conceive after 12 months of intercourse without contraception.*

- 7.1d Reduce homicides among Hispanic men aged 15 through 34 to no more than 42.5 per 100,000 Hispanic men. (Baseline: 53.1 per 100,000 in 1987)

- 8.1b\* Increase years of healthy life among Hispanics to at least 65 years. (Baseline: An estimated 62 years in 1980)
- Note: Years of healthy life (also referred to as quality-adjusted life years) is a summary measure of health that combines mortality (quantity of life) and morbidity and disability (quality of life) into a single measure. For people aged 65 and older, active life-expectancy, a related summary measure, also will be tracked.*
- 8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)
- Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.*
- 13.2d Reduce untreated dental caries so that the proportion of Hispanic children with untreated caries (in permanent or primary teeth) is no more than 25 percent among children aged 6 through 8 and no more than 25 percent among adolescents aged 15. (Baseline: 36 percent of Hispanic children aged 6 through 8 in 1982-84; 31-47 percent of Hispanic adolescents aged 15 in 1982-84)
- 13.5c Reduce the prevalence of gingivitis among Hispanics aged 35 through 44 to no more than 50 percent. (Baseline: 74 percent among Mexican Americans; 79 percent among Cubans; 82 percent among Puerto Ricans; in 1982-84)
- 14.1c Reduce the infant mortality rate among Puerto Ricans to no more than 8 per 1,000 live births. (Baseline: 12.9 per 1,000 live births in 1984)
- 14.1f Reduce the neonatal mortality rate among Puerto Ricans to no more than 5.2 per 1,000 live births. (Baseline: 8.6 per 1,000 live births in 1984)
- 14.1j Reduce the postneonatal mortality rate among Puerto Ricans to no more than 2.8 per 1,000 live births. (Baseline: 4.3 per 1,000 live births in 1984)
- Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.*
- 14.9c\* Increase to at least 75 percent the proportion of Hispanic mothers who breastfeed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 51 percent at discharge from birth site and 16 percent at 5 to 6 months in 1988)
- 14.11c Increase to at least 90 percent the proportion of pregnant Hispanic women who receive prenatal care in the first trimester of pregnancy. (Baseline: 61.0 percent of live births in 1987)
- Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.*
- 16.11a Increase to at least 80 percent the proportion of Hispanic women aged 40 and older who have ever received a clinical breast examination and a mammogram, and to at least 60 percent those aged 50 and older who have received them within the preceding 1 to 2 years. (Baseline: 20 percent of Hispanic women aged 40 and older "ever" in 1987; 18 percent of Hispanic women aged 50 and older "within the preceding 2 years" in 1987)
- 16.12a Increase to at least 95 percent the proportion of Hispanic women with uterine cervix who have ever received a Pap test, and to at least 80 percent those who received a Pap test within the preceding 1 to 3 years. (Baseline: 75 percent "ever" and 66 percent "within the preceding 3 years" in 1987)
- 17.11b Reduce diabetes among Puerto Ricans to a prevalence of no more than 49 per 1,000 Puerto Ricans. (Baseline: 55 per 1,000 aged 20 through 74 in 1982-84)
- 17.11c Reduce diabetes among Mexican Americans to a prevalence of no more than 49 per 1,000 Mexican Americans. (Baseline: 54 per 1,000 aged 20 through 74 in 1982-84)
- 17.11d Reduce diabetes among Cuban Americans to a prevalence of no more than 32 per 1,000 Cuban Americans. (Baseline: 36 per 1,000 aged 20 through 74 in 1982-84)
- 18.1c Confine annual incidence of diagnosed AIDS cases among Hispanics to no more than 18,000 cases. (Baseline: An estimated 7,000-8,000 cases diagnosed in 1989)
- Note: Targets for this objective are equal to upper bound estimates of the incidence of diagnosed AIDS cases projected for 1993.*
- 20.4c Reduce tuberculosis among Hispanics to an incidence of no more than 5 cases per 100,000 Hispanics. (Baseline: 18.3 per 100,000 in 1988)



- 21.2i Increase to at least 50 percent the proportion of Hispanics who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)
- 21.3a Increase to at least 95 percent the proportion of Hispanics who have a specific source of ongoing primary care for coordination of their preventive and episodic health care. (Baseline: Less than 70 percent in 1986, as 30 percent reported having no physician, clinic, or hospital as a regular source of care)
- 21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

	1985-1986 Baseline	2000 Target
Hispanics	3%	6.4%

*Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.*

- 22.4 Develop and implement a national process to identify significant gaps in the nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)
- Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.*

## Objectives Targeting Asians and Pacific Islanders

- 2.4d Reduce growth retardation among low-income Asian and Pacific Islander children aged 1 to less than 10 percent. (Baseline: 14 percent in 1988)
- Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*
- 2.4e Reduce growth retardation among low-income Asian and Pacific Islander children aged 2 through four to less than 10 percent. (Baseline: 16 percent in 1988)
- Note: Growth retardation is defined as height-for-age below the fifth percentile of children in the National Center for Health Statistics' reference population.*
- 3.4g\* Reduce cigarette smoking to a prevalence of no more than 20 percent among Southeast Asian men. (Baseline: 55 percent in 1984-88)
- Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*
- 8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)
- Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.*
- 20.3d\* Reduce Hepatitis B (HBV) among children of Asians and Pacific Islanders to no more than 1,800 cases. (Baseline: An estimated 8,900 cases in 1987)
- 20.4a Reduce tuberculosis among Asians and Pacific Islanders to an incidence of no more than 15 cases per 100,000 Asians and Pacific Islanders. (Baseline: 36.3 per 100,000 in 1988)
- 21.2j Increase to at least 50 percent the proportion of Asians and Pacific Islanders who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)

- 22.4 Develop and implement a national process to identify significant gaps in the nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

*Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.*

## Objectives Targeting American Indians and Alaska Natives

- 2.3d\* Reduce overweight to a prevalence of no more than 30 percent among American Indians and Alaska Natives. (Baseline: An estimated 29-75 percent for different tribes in 1984-88)

*Note: For people aged 20 and older, overweight is defined as body mass index (BMI) equal to or greater than 27.8 for men and 27.3 for women. For adolescents, overweight is defined as BMI equal to or greater than 23.0 for males aged 12 through 14, 24.3 for males aged 15 through 17, 25.8 for males aged 18 through 19, 23.4 for females aged 12 through 14, 24.8 for females aged 15 through 17, and 25.7 for females aged 18 through 19. The values for adolescents are the age- and gender-specific 85th percentile values of the 1976-80 National Health and Nutrition Examination Survey (NHANES II), corrected for sample variation. BMI is calculated by dividing weight in kilograms by the square of height in meters. The cut points used to define overweight approximate the 120 percent of desirable body weight definition used in the 1990 objectives.*

- 2.10d Reduce the prevalence of anemia to less than 10 percent among Alaska native children aged 1 through 5. (Baseline: 22-28 percent in 1983-85)

*Note: Iron deficiency is defined as having abnormal results for 2 or more of the following tests: mean corpuscular volume, erythrocyte protoporphyrin, and transferrin saturation. Anemia is used as an index of iron deficiency. Anemia among Alaska Native children was defined as hemoglobin <11 gm/dL or hematocrit <34 percent. For pregnant women in the third trimester, anemia was defined according to CDC criteria. The above prevalences of iron deficiency and anemia may be due to inadequate dietary iron intakes or to inflammatory conditions and infections. For anemia, genetics may also be a factor.*

- 3.4f\* Reduce cigarette smoking to a prevalence of no more than 20 percent among American Indians and Alaska Natives. (Baseline: An estimated 42-70 percent for different tribes in 1979-87)

*Note: A cigarette smoker is a person who has smoked at least 100 cigarettes and currently smokes cigarettes.*

- 3.9a Reduce smokeless tobacco use by American Indian and Alaska Native youth to a prevalence of no more than 10 percent. (Baseline: 18-64 percent in 1987)

*Note: For males aged 12 through 17, a smokeless tobacco user is someone who has used snuff or chewing tobacco in the preceding month. For males aged 18 through 24, a smokeless tobacco user is someone who has used either snuff or chewing tobacco at least 20 times and who currently uses snuff or chewing tobacco.*

- 4.1a Reduce deaths among American Indian and Alaska Native men caused by alcohol-related motor vehicle crashes to no more than 44.8 per 100,000 American Indian and Alaska Native men. (Age-adjusted baseline: 52.2 per 100,000 in 1987)

- 4.2b Reduce cirrhosis deaths among American Indians and Alaska Natives to no more than 13 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 25.9 per 100,000 in 1987)

- 6.1d\* Reduce suicides among American Indian and Alaska Native men in Reservation States to no more than 12.8 per 100,000 American Indian and Alaska Native men. (Age-adjusted baseline: 15 per 100,000 in 1987)

- 7.1f Reduce homicides among American Indians and Alaska Natives in Reservation States to no more than 11.3 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 14.1 per 100,000 in 1987)

- 8.11 Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. (Baseline data available in 1992)

*Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.*

- 9.1a Reduce deaths among American Indians and Alaska Natives caused by unintentional injuries to no more than 66.1 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 82.6 per 100,000 in 1987)



- 9.3d Reduce deaths among American Indians and Alaska Natives caused by motor vehicle crashes to no more than 39.2 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 46.8 per 100,000 in 1987)
- 13.1b Reduce dental caries (cavities) so that the proportion of American Indian and Alaska Native children aged 6 through 8 with one or more caries (in permanent or primary teeth) is no more than 45 percent. (Baseline: 92 percent in primary teeth and 52 percent in permanent teeth in 1983-84)
- 13.1d Reduce dental caries (cavities) so that the proportion of American Indian and Alaska Native adolescents aged 15 with one or more caries (in permanent or primary teeth) is no more than 70 percent. (Baseline: 93 percent in permanent teeth in 1983-84)
- 13.2b Reduce untreated dental caries so that the proportion of American Indian and Alaska Native children with untreated caries (in permanent or primary teeth) is no more than 35 percent among children aged 6 through 8 and no more than 40 percent among adolescents aged 15. (Baseline: 64 percent of American Indian and Alaska Native children aged 6 through 8 in 1983-84; 84 percent of American Indian and Alaska Native adolescents aged 15 in 1983-84)
- 13.5b Reduce the prevalence of gingivitis among American Indians and Alaska Natives aged 35 through 44 to no more than 50 percent. (Baseline: 95 percent in 1983-84)
- 13.11b\* Increase to at least 65 percent the proportion of American Indian and Alaska Native parents and caregivers who use feeding practices that prevent baby bottle tooth decay. (Baseline data available in 1991)
- 14.1b Reduce the infant mortality rate among American Indians and Alaska Natives to no more than 8.5 per 1,000 live births. (Baseline: 12.5 per 1,000 live births in 1984)
- 14.1i Reduce the postneonatal mortality rate among American Indians and Alaska Natives to no more than 4 per 1,000 live births. (Baseline: 6.5 per 1,000 live births in 1984)  
*Note: Infant mortality is deaths of infants under 1 year; neonatal mortality is deaths of infants under 28 days; and postneonatal mortality is deaths of infants aged 28 days up to 1 year.*
- 14.4a Reduce the incidence of fetal alcohol syndrome among American Indians and Alaska Natives to no more than 2 per 1,000 live births. (Baseline: 4 per 1,000 live births in 1987)
- 14.9d\* Increase to at least 75 percent the proportion of American Indian and Alaska Native mothers who breastfeed their babies in the early postpartum period, and to at least 50 percent the proportion who continue breastfeeding until their babies are 5 to 6 months old. (Baseline: 47 percent at discharge from birth site and 28 percent at 5 to 6 months in 1988)
- 14.11b Increase to at least 90 percent the proportion of pregnant American Indian and Alaskan Native women who receive prenatal care in the first trimester of pregnancy. (Baseline: 60.2 percent of live births in 1987)
- 17.2b Reduce to no more than 11 percent the proportion of American Indians and Alaska Natives who experience a limitation in major activity due to chronic conditions. (Baseline: 13.4 percent in 1983-85)  
*Note: Major activity refers to the usual activity for one's age-gender group whether it is working, keeping house, going to school, or living independently. Chronic conditions are defined as conditions that either (1) were first noticed 3 or more months ago, or (2) belong to a group of conditions such as heart disease and diabetes, which are considered chronic regardless of when they began.*
- 17.9b Reduce diabetes-related deaths among American Indians and Alaska Natives to no more than 48 per 100,000 American Indians and Alaska Natives. (Age-adjusted baseline: 54 per 100,000 in 1986)  
*Note: Diabetes-related deaths refer to deaths from diabetes as an underlying or contributing cause.*
- 17.10b Reduce end-stage renal disease due to diabetes among American Indians and Alaska Natives with diabetes to no more than 1.9 per 1,000 American Indians and Alaska Natives with diabetes. (Baseline: 2.1 per 1,000 in 1983-86)  
*Note: End-stage renal disease (ESRD) is defined as requiring maintenance dialysis or transplantation and is limited to ESRD due to diabetes. Blindness refers to blindness due to diabetic eye disease.*
- 17.11a Reduce diabetes among American Indians and Alaska Natives to a prevalence of no more than 62 per 1,000 American Indians and Alaska Natives. (Baseline: 69 per 1,000 aged 15 and older in 1987)

- 20.3g\* Reduce Hepatitis B (HBV) among Alaska Natives to no more than 1 case. (Baseline: An estimated 15 cases in 1987)
- 20.4d Reduce tuberculosis among American Indians and Alaska Natives to an incidence of no more than 5 cases per 100,000 American Indians and Alaska Natives. (Baseline: 18.1 per 100,000 in 1988)
- 20.7a Reduce bacterial meningitis among Alaska Natives to no more than 8 cases per 100,000 Alaska Natives. (Baseline: 33 per 100,000 in 1987)
- 21.2k Increase to at least 70 percent the proportion of American Indians and Alaska Natives who have received, as a minimum within the appropriate interval, all of the screening and immunization services and at least one of the counseling services appropriate for their age and gender as recommended by the U.S. Preventive Services Task Force. (Baseline data available in 1991)
- 21.8 Increase the proportion of all degrees in the health professions and allied and associated health profession fields awarded to members of underrepresented racial and ethnic minority groups as follows:

	1985-1986 Baseline	2000 Target
American Indians and Alaska Natives	0.3%	0.6%

*Note: Underrepresented minorities are those groups consistently below parity in most health profession schools—blacks, Hispanics, and American Indians and Alaska Natives.*

- 22.4 Develop and implement a national process to identify significant gaps in the Nation's disease prevention and health promotion data, including data for racial and ethnic minorities, people with low incomes, and people with disabilities, and establish mechanisms to meet these needs. (Baseline: No such process exists in 1990)

*Note: Disease prevention and health promotion data includes disease status, risk factors, and services receipt data. Public health problems include such issue areas as HIV infection, domestic violence, mental health, environmental health, occupational health, and disabling conditions.*



## APPENDIX B

### OFFICE OF MINORITY HEALTH:

### ITS MISSION AND STRATEGIC PLANNING PROCESS

#### ORIGIN AND MISSION OF OMH

In response to the 1985 *Report of the Secretary's Task Force on Black and Minority Health*, then Department of Health and Human Services Secretary Margaret Heckler established the Office of Minority Health within the Office of the Assistant Secretary for Health, Public Health Service.

The Office of Minority Health was created to implement the recommendations of the Secretary's Task Force Report. The mission of the Office is described as a "coordinative and advocacy role," with responsibility for performing the following activities:

- Establish near-term and long-range objectives for DHHS health activities that address minority populations.
- Develop reporting and monitoring requirements consistent with these objectives.
- Organize and plan specific activities to meet minority health needs and to monitor the DHHS budget to ensure that an appropriate share of funds is devoted to minority health problems.
- Provide ongoing technical assistance to states and work closely with public and private sectors to ensure that minority health issues are addressed.
- Serve as a resource in the promotion, investigation, development, and implementation of innovative health models that are culturally unique to minority populations.
- Develop and review strategies to improve the availability and accessibility of health professionals to minority populations.
- Conduct, sponsor, and facilitate conferences on minority health.
- Ensure that steps are taken to improve data sources and to integrate data systems reflecting minority populations.
- Facilitate research and foster public awareness of research in factors affecting minority health.
- Organize and plan specific activities while ensuring appropriate departmental allocation of resources and attention to the problems.

The role of OMH was expanded and redefined with the passage of the Disadvantaged Minority Health Improvement Act of 1990 (P.L. 101-527). The purpose of the act is to raise the level of national commitment to improving health

care for all Americans. This legislation is targeted at lessening the growing health gap between minorities and nonminorities. Specifically, this act attempts to accomplish this in three ways:

- By increasing support for health promotion and disease prevention activities designed to reduce the occurrence of illnesses prevalent among disadvantaged minorities.
- By authorizing OMH with funding authority to carry out its responsibility and mandate.
- By increasing the supply of minority health professionals in the United States.

The location of OMH as a staff office within the Office of the Assistant Secretary for Health and the designation of its Director as Deputy Assistant Secretary for Minority Health and a senior advisor to the Assistant Secretary and the Secretary of DHHS on matters related to minority health underscore the most critical function of OMH. It must continuously encourage planning and coordination of minority-targeted programs and activities across the Public Health Service and the Department, as well as in other Federal agencies, and the public and private sectors.

#### **STRATEGIC PLANNING AND COORDINATION**

The Office of Minority Health recognized early on that two elements are crucial to accomplishing its mission:

- Ongoing involvement and support of its efforts from the broad community.
- A strategic planning process that would ensure routine coordination of minority-focused activities across the Department.

With assistance from outside consultants and advice from agency representatives, OMH developed the strategic planning and coordination process, which resulted in the strategies presented in this report. This planning and coordination process has consisted of the following stages of evolution:

- Stage I: Minority Health Coordination Activities (1986 and continuing).
- Stage II: Strategic Planning and Coordination Process (1987-1990).

The following sections describe the activities that have been accomplished in each of the stages of this strategic planning process. This process is graphically illustrated in exhibit 1.

#### ***Stage I: Minority Health Coordination Activities***

During its first few years of operation, OMH was involved in planning and coordinating a variety of activities that focused on coalition building and network development. These activities included providing outreach to grassroots organizations, working closely with both the public and the private sectors, facilitating information exchange within PHS as well as across the Department, providing conference support and participation, awarding community demonstration grants, and monitoring PHS programs.

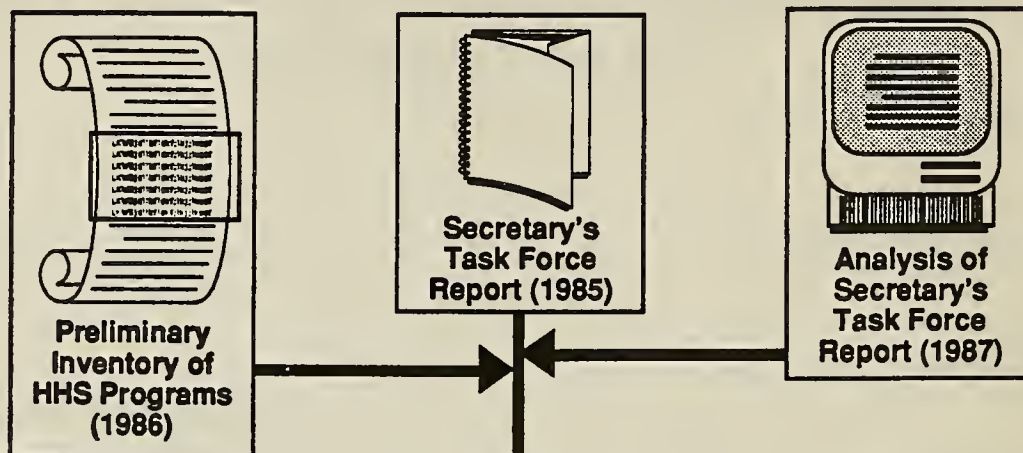
**EXHIBIT 1: Evolution of PHS Strategic Planning and Coordination  
Process and System**

**Stage I: Office of Minority Health Coordination Activities  
(1986 and Continuing)**

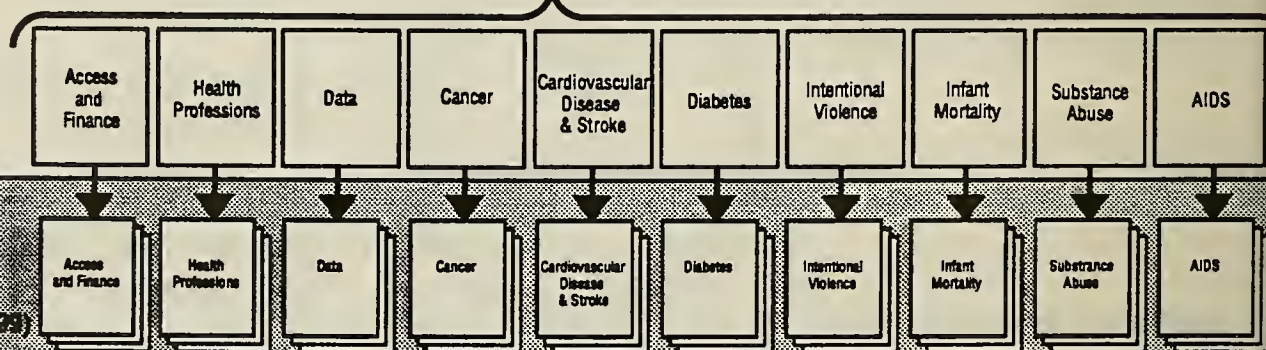




## Stage II: OMH Strategic Planning and Coordination Process (1987-1990)

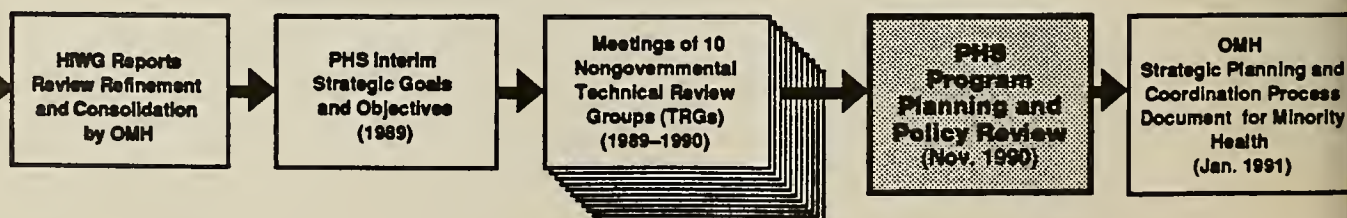


Selection of 10 Intragovernmental Health Issues Working Groups (HIWGs) (1987)



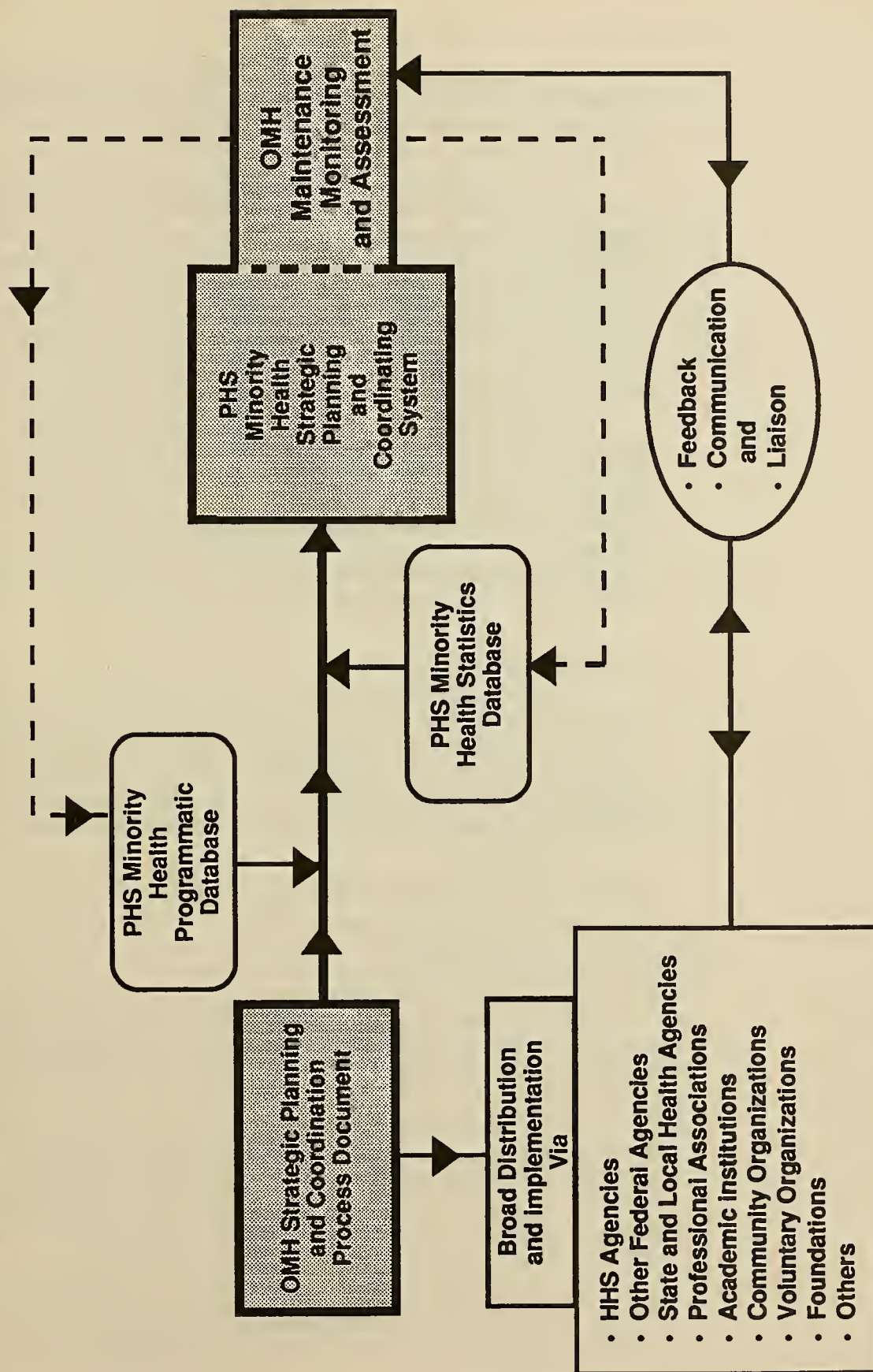
### Other OMH Sources

- Workshops
- New Initiatives
- Conferences
- Directives
- Year 2000
- Etc.





# Stage III: PHS Minority Strategic Planning and Coordination System (1991 and Beyond)



From the beginning, OMH also was called on to respond to various types of legislative and public inquiries. The Office used the results of the coalition building and networking activities mentioned above to respond to many of these requests and to identify additional sources of information.

The activities that OMH conducted and supported during these early years were successful in their own rights. In addition, they stimulated followup programming in minority communities across the country. But they were not part of an overall plan. In many instances, the activities were in reaction to needs perceived and identified by individuals and organizations outside of the Office. But they did provide information about activities and approaches being used in the field, and they increased OMH's understanding of the major players in these activities.

### ***Stage II: OMH Strategic Planning and Coordination Process***

The Office understood from the beginning that its mission dictated that it be able to accomplish complex activities and to expand, when necessary, in new directions to respond to changing opportunities and challenges in minority health. OMH began to develop a strategic planning process that would reflect a broad consensus regarding the priority emphasis areas as well as the most appropriate strategies and approaches to address them. This broad consensus would include input from people and participation by organizations outside of the Federal Government as well as various agency representatives.

### ***Information Gathering Activities***

The first activity OMH undertook in the development of the strategic planning and coordination process was a complete analysis of the eight-volume Secretary's Task Force Report. The report contained 431 recommendations covering a wide range of health issues that significantly contribute to the disparities in health status between minority and majority populations in this country. These recommendations were subdivided into the following general categories:

- Research
- Information and education
- Health professions development
- Access and delivery
- Financing.

Most recommendations also related to one of the following particular diseases or conditions: cancer; cardiovascular disease and stroke; diabetes; homicide, suicide, and unintentional injuries; infant mortality and low birthweight; or substance abuse.

Next, OMH conducted a preliminary analysis of existing minority-focused programs within the Public Health Service. With assistance from agency representatives and PHS database managers, OMH determined the level of activity in each of the priority health issue areas emphasized in the Secretary's Task Force Report. This analysis resulted in the development of a preliminary inventory of DHHS programs.

Both the analysis of the Task Force Report and the preliminary inventory of DHHS programs provided useful background information for developing the strategic planning and coordination process. This information assisted the Office in

identifying the health areas in which particular emphasis is needed, determining the level of departmental activity in those particular areas, and identifying areas where principal OMH resources should be directed.

### ***Establishment of the Health Issues Working Groups***

OMH was well aware of the importance of involving representatives from PHS agencies in the early stages of the planning process. Such involvement would serve to inform these decisionmakers about the roles their respective agencies would be expected to play in implementing and monitoring certain aspects of the plan and in supporting and coordinating critical activities related to the strategic planning and coordination process. In addition, it was expected that with this knowledge, these agencies would be encouraged to incorporate appropriate elements of the strategic planning and coordination process into their routine planning and coordination efforts in a timely and logical manner.

Therefore, the Office established nine Health Issues Working Groups (HIWGs), each of which corresponded to OMH's priority health issue areas:

- Cancer
- Cardiovascular disease and stroke
- Diabetes
- Infant mortality and low birthweight
- Substance abuse
- Violence
- Access and health care financing
- Health care data
- Health professions development.

These nine health issue areas were cited in the Secretary's Task Force Report as contributing significantly to excess deaths in minority populations. OMH later added a 10th issue,

HIV/AIDS, because of its devastating impact on minority populations, especially among Blacks and Hispanics.

The Health Issues Working Groups were composed of representatives from across PHS, as listed in appendix C. The groups were convened to assist OMH in its ongoing assessment of minority health needs and the resources available to meet those needs. During their deliberations, the HIWGs consulted several sources, including the OMH analysis of the Task Force recommendations and the preliminary inventory of DHHS programs. They considered the current level of activity in each of the priority health issue areas, identified gaps as well as overlapping areas, and suggested alternatives that could enhance current program activities.

The primary role of these HIWGs was to draft strategic goals and objectives for improving minority health, for which the groups received specific guidelines. OMH directed that goal statements:

- Be circumscribed by assessable performance indicators (i.e., qualitative or quantitative).
- Focus on measurable aspects of program intent.
- Indicate final, desired end results.
- Represent a long-range focus.



In terms of development of the strategic objectives, the HIWGs were directed that these objectives should:

- Provide further indication of areas contained in the goals.
- Specify single end results.
- Imply a timeframe (i.e., immediate, short term, medium term, long term, continuing).
- Avoid overlap with other objectives.
- Be associated with measurable criteria.

The HIWGs summarized the results of their work in individual reports and submitted these reports to the Office of Minority Health. OMH then reviewed and consolidated these reports. Other source materials also were used to supplement the HIWG reports and to refine the goals and objectives. These sources included new initiatives within the Department, information and materials from conferences and workshops, and various administrative directives.

No HIWG was convened to address the issue of HIV/AIDS. Instead, OMH used outside consultants to draft strategic goals and objectives, following the same guidelines given to all the HIWGs. The consultants reviewed the literature and worked directly with PHS agency representatives involved with HIV/AIDS issues to determine the most crucial issues related to this national health problem. After the consultants completed their deliberations, they submitted their report to OMH.

Later, OMH developed interim strategic goals and objectives for each of the 10 priority health issue areas based on the work of the HIWGs and the working group convened to address HIV/AIDS, review of supplemental background materials, and consultation with other agency representatives. These goals and objectives included proposed timeframes and requirements for implementation phasing. At this stage, OMH determined that questions related to priority ranking and timing would be most appropriately addressed during the later stages of the planning process.

### ***Establishment of the Technical Review Groups***

The work of the Health Issues Working Groups represented meaningful Federal input to the priority health issue areas that adversely affect minority communities. However, OMH was well aware that direct input from the broad community also was needed. Therefore, the Office began to identify non-Federal health experts to serve on Technical Review Groups (TRGs). Members of the TRGs represented a cross-section of the broad community: community-based programs, colleges and universities, state health departments, community hospitals, tribal councils, health maintenance organizations, health policy institutes and research centers, community health centers, and national organizations. Appendix C presents a complete listing of these groups.

These members were identified from consultations with OMH staff, OMH grantees, PHS contacts, as well as individuals working with minority populations across the country. Much time and attention went into selecting the most appropriate people to participate in this stage of the review process. It was important that members reflect an ethnic balance and a variety of expertise to ensure that the cultural diversity found in minority communities was appropriately represented.

Each of the TRGs also included the chairperson of the corresponding Health Issues Working Group. The sole responsibility of these HIWG chairpersons was to serve as resources to the TRGs, specifically to clarify the language and intent of the

draft strategic goals and objectives and to ensure continuity throughout the planning process.

TRG members were asked to examine the development of the strategic planning process to date and to use their specialized expertise to help OMH accomplish the following:

- Refine the interim strategic goals and objectives.
- Rank goals and objectives to guide OMH/DHHS in choosing activities to be undertaken and administrative decisions to be made.
- Indicate the appropriate phasing, sequence, and scheduling of implementation activities.

The TRG meetings were convened over a 75-day period. Each of the groups met for 1 day. Before each meeting, members were asked to respond to the following issues in relation to the goals and objectives developed by the HIWGs:

- Is the objective technically and scientifically accurate and reasonable?
- Is the size of the affected population large or small?
- Have minority community members and health professionals expressed an interest in the area described by the goal or objective?
- Would the goal or objective be reasonably easy to implement?
- What are the existing barriers to implementation? Can these barriers be overcome?
- What quantifiable indicators would be the most appropriate to measure progress and outcomes for the goals or objectives?
- What organizations would be instrumental in implementing the goal or objective?

OMH staff and consultants worked with each of the TRG chairpersons before the review meetings. These premeeting briefings included discussions of the ongoing strategic planning process, the role of the TRG chairpersons, as well as the meeting format and goals. TRG chairpersons also received an analysis of the responses submitted by the review group members. With this information, the chairpersons were able to determine the best approach for conducting their respective working sessions.

Group discussions during each TRG meeting were documented by OMH staff and consultants. After each meeting, consultants analyzed the results and submitted them to OMH and the TRG chairpersons. The goals and objectives in each health issue area then were revised to reflect input from the technical reviewers. Throughout the revision of goals and objectives, consultants and OMH staff worked with the TRG chairpersons to clarify any discrepancies in language and content. When necessary, TRG chairpersons also consulted with specific TRG members to ensure that community perspectives were accurately reflected. Finally, results of the TRG meetings were incorporated into the ongoing strategic planning and coordination process.

The significance of the work of the TRGs cannot be overemphasized. They provided non-Federal responses to the interim strategic goals and objectives developed by the Federal representatives who served on the Health Issues Working Groups. TRG members brought with them not only their technical expertise, but also their understanding and appreciation of the health practices and beliefs as well as the health status of minorities living in various types of communities across the country.

***PHS Programming, Planning, and Policy Review***

Results of the work of the HIWGs and the TRGs were incorporated into a draft document, which was submitted to PHS representatives who are directly involved in program planning and policy decisions. These Federal reviewers were asked to respond to a number of questions about the information contained in the document and the manner in which the information was presented. Responses from the program and policy review phase were used to refine this document, which includes more than 500 strategies related to the 10 priority health issue areas for Asian and Pacific Islander, Black, Hispanic, and Native American populations.

*Toward Equality of Well-Being: Strategies for Improving Minority Health* serves as a focal point for Federal and non-Federal interests, including the broad health community, researchers, government health agencies, media, foundations, and the general public. Among other things, this document identifies areas that researchers and health professionals can use to develop health research agendas and service delivery programs. Furthermore, others will be able to use the goals and objectives presented to increase their understanding of potential paths to follow in addressing current issues in minority health, including funding and program development in areas of particular need.

Ultimately, each agency within PHS will be able to compare its programmatic activities with these strategies to determine whether its programs are consistent in terms of overall thrust, focus, and direction.



## APPENDIX C

### MEMBERS OF HEALTH ISSUES WORKING GROUPS AND TECHNICAL REVIEW GROUPS

#### HEALTH ISSUES WORKING GROUPS MEMBERSHIP\*

##### *Access and Health Care Financing*

- |   |                                 |
|---|---------------------------------|
| • Center for Prevention Services, CDC               | Alice Ring                      |
| • Health Care Financing Administration              | William Winkenwerder<br>(Chair) |
| • Health Resources and Services<br>Administration   | Ronald Carlson (Co-chair)       |
| • National Center for Health Statistics, CDC        | Jacqueline Davis                |
| • National Institute of Mental Health,<br>ADAMHA    | Bernard Arons                   |
| • Office of Financing and Coverage Policy<br>ADAMHA | James Kaple                     |
| • Office of Health Planning and Evaluation<br>OASH  | Phyllis Zucker                  |

##### *Alcohol, Tobacco, and Other Drug Dependency*

- |  |                      |
|--|----------------------|
| • Bureau of Health Care Delivery<br>and Assistance, HRSA           | Vivian Chen          |
| • Food and Drug Administration                                     | Timothy Sottek       |
| • Health Care Financing Administration                             | Judy Boggs           |
| • Indian Health Service  | Eva Smith            |
| • National Institute of Child Health and<br>Human Development, NIH | Norman Krasnegor     |
| • National Institute on Alcohol Abuse and<br>Alcoholism, ADAMHA    | Loren Archer (Chair) |
| • National Institute on Drug Abuse,<br>ADAMHA                      | Jean Paul Smith      |
| • Office of Human Development Services                             | Jack Corrigan        |
| • Office of Smoking and Health, CDC                                | Ronald Davis         |

##### *Cancer*

- |  |                    |
|--|--------------------|
| • Center for Environmental Health, CDC | Richard Rothenberg |
|--|--------------------|

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\* Membership changed over time as the process evolved.

- Food and Drug Administration John Johnson
- Health Resources and Services Administration Allan Noonan
- National Cancer Institute, NIH Barbara Bynum (Chair)  
Gail Bryant (Co-chair)
- National Institute on Aging, NIH Evan Hadley
- Office of Disease Prevention and Health Promotion, OASH Steven Woolf

### ***Cardiovascular Disease and Stroke***

- Bureau of Eligibility, Reimbursement, and Coverage, HCFA Jake Culp
- Center for Health Promotion and Education, CDC Frederick Trowbridge
- Food and Drug Administration Martin Rose
- Health Resources and Services Administration William Robinson
- National Center for Health Statistics, CDC Daniel Savage
- National Heart, Lung, and Blood Institute, NIH Barbara Packard (Chair)  
Barbara James (Co-chair)
- National Institute of Neurological Diseases and Stroke, NIH Michael Walker
- National Institute on Aging, NIH Shirley Bagley
- National Institute on Alcohol Abuse and Alcoholism, ADAMHA Boris Tabakoff
- Office of Disease Prevention and Health Promotion, OASH Angela Mickalide

### ***Data Development***

- Bureau of Health Professions, HRSA Darl Stephens
- Epidemiology Program Office, CDC James Buehler
- National Center for Health Statistics, CDC Patricia Golden (Chair)
- National Institute of Mental Health, ADAMHA Benjamin Locke
- National Institute on Alcohol Abuse and Alcoholism, ADAMHA Mary DeFour
- Office of Disease Prevention and Health Promotion, OASH Gregory Christenson
- Office of Health Planning and Evaluation, OASH Nancy Pearce
- Social Security Administration Martynas Ycas

### ***Diabetes***

- |   |                 |
|---|-----------------|
| • Bureau of Health Care Delivery and Assistance, HRSA                               | Joyce Young     |
| • Center for Prevention Services, CDC   | Alice Ring      |
| • Food and Drug Administration  | Ross Pierce     |
| • Indian Health Service   | Dorothy Ghodes  |
| • National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases, NIH | Johnson (Chair) |
| • Office of Disease Prevention and Health Promotion, OASH                           | Robert Fried    |
| • Office of Health Planning and Evaluation, OASH                                    | Valerie Setlow  |

### ***Health Professions***

- |   |                      |
|---|----------------------|
| • Bureau of Health Professions, HRSA          | Clay Simpson (Chair) |
| • Epidemiology Program Office, CDC            | Richard Goodman      |
| • National Center for Health Statistics, CDC  | Sheldon Starr        |
| • National Center for Nursing Research, NIH   | Ada Sue Hinshaw      |
| • National Institute of Mental Health, ADAMHA | Sam Silverstein      |
| • Special Assistant to the Director, NIH      | Doris Merritt        |

### ***Homicide, Suicide, and Unintentional Injuries***

- |  |                           |
|--|---------------------------|
| • Bureau of Health Care Delivery and Assistance, HRSA    | Arthur Funke              |
| • Center for Environmental Health, CDC                   | Stuart Brown (Co-chair)   |
| • Indian Health Service                                  | Richard Smith             |
| • National Institute of Mental Health, ADAMHA            | Delores Parron (Co-chair) |
| • Office of Disease Prevention and Health Promotion, NIH | Jack Kalberer             |
| • Office of Human Development Services                   | Sandra Spaulding          |

### ***Infant Mortality***

- |  |                     |
|--|---------------------|
| • Bureau of Health Care Delivery and Assistance, HRSA      | Ann Koontz          |
| • Center for Health Promotion and Education, CDC           | Carol Hogue (Chair) |
| • Division of Evaluation and Research Coordination, ADAMHA | Ed Rushton          |
| • Division of Policy Analysis, HCFA                        | Thomas Gustafson    |



- National Heart, Lung, and Blood Institute, NIH      Clarice Reid
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